

**CULTURAL BELIEFS AND PRACTICES OF MOTHERS TOWARDS
NEONATAL HEALTH IN IGABI LOCAL GOVERNMENT AREA OF KADUNA
STATE, NIGERIA**

BY

SAADATU, MOHAMMED SANI

**DEPARTMENT OF NURSING SCIENCE
FACULTY OF MEDICINE
AHMADU BELLO UNIVERSITY
ZARIA, NIGERIA**

JUNE, 2017

**CULTURAL BELIEFS AND PRACTICES OF MOTHERS TOWARDS
NEONATAL HEALTH IN IGABI LOCAL GOVERNMENT AREA OF KADUNA
STATE, NIGERIA**

BY

**Saadatu MOHAMMED SANI. BNSc
P13/MD/NS/8030**

**ADISSERTATION SUBMITTED TO THE SCHOOL OF POSTGRADUATE
STUDIES, AHMADU BELLO UNIVERSITY ZARIA, NIGERIA**

**IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR THE AWARD
OF MASTER DEGREE IN NURSING SCIENCE**

**DEPARTMENT OF NURSING SCIENCE,
FACULTY OF MEDICINE,
AHMADU BELLO UNIVERSITY,
ZARIA, NIGERIA**

JUNE, 2017

Declaration

I declare that this dissertation entitled “**CULTURAL BELIEFS AND PRACTICES OF MOTHERS TOWARDS NEONATAL HEALTH IN IGABI L.G.A OF KADUNA STATE, NIGERIA**” has been performed by me in the department of Nursing Science ABU Zaria. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this research work has been submitted for another degree or diploma at this or any other institution.

Saadatu MOHAMMED SANI

.....

Signature

.....

Date

Certification

This dissertation entitled “**CULTURAL BELIEFS AND PRACTICES OF MOTHERS TOWARDS NEONATAL HEALTH IN IGABI L.G.A OF KADUNA STATE, NIGERIA**” by Saadatu MOHAMMED SANI meets the regulations governing the award of Master of Nursing Science of Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation

Professor Hayat Gomma

.....

Signature.....

Date.....

Chairman, supervisory committee

Dr. Tukur B. M.

.....

Signature.....

Date.....

Member, supervisory committee

Dr. S. N.Garba

.....

Signature.....

Date.....

Head of Department

Prof. S. Z. Abubakar

.....

Signature.....

Date.....

Dean, School of Post Graduate Studies

Acknowledgement

The Almighty Allah first in everything, for He is the secret interpreter of knowledge to whom He so wishes.

The researcher sincerely acknowledges with gratitude, the support, encouragement, cooperation and suggestion of her able Supervisors, Professor Hayat Gomma and Dr. Tukur B.M they have showed love and concern to the researcher. To this end the researcher remain exceptionally thankful to you.

In general, the researcher acknowledges the support and assistance of all academic and non- academic Staff of the Department of Nursing Science Ahmadu Bello University Zaria. The contributions of her colleagues are hereby acknowledged and those that are spiritually together with her.

The researcher wishes to deviate her acknowledgement back home to thank her husband Hon. Engr, Mohammed A Haruna for his kind support, kids Aisha, Nafisa, Zainab, Zakiyya, Khalifa, Walida, Afrah, Mimi, little Abdallah and all her sisters, brothers, and friends. The researcher will never forget the effort of her driver Mal Sunusi Adam, Baban Amir Printer, Fatima Y Bello, Fatima Balarabe and Ramatu Salisu for their wonderful sacrifices.

Finally, the researcher acknowledges all forms of assistance given to her of those she had not mentioned their names.

Abstract

Cultural practices consist of the beliefs and practices held or observed through grandparents, parents and the society. There are various cultural practices which affect the neonate. Harmful cultural practices are those practices that are known to have negative effects on neonatal health. The aim of this study was to explore the cultural beliefs and practices on neonatal health among mothers in Igabi LGA of Kaduna State. A cross sectional descriptive design was adopted. A total of 400 mothers were recruited through multistage sampling technique during the period of October 2016 to December 2016. A semi-structured questionnaire was the main tool for data collection. All ethical consideration was kept during the study phases. Statistical package for Social Science (SPSS) version 20 was used for data analysis. The findings revealed that: Majority of the mothers 333 (85.9%) were between the age range of 21 – 40 years old. Ninety five point one percent were Muslims. More than half of the mothers 257(66.5%) were unemployed. Also (57%) delivered their babies at home where (53%) of them had unplanned deliveries. Seventy percent of them delivered in the presence of unskilled health providers. The mothers accepted the cultural practices regarding neonatal feeding (60%), and care during neonatal illness (53%). Cultural beliefs (46.8%) and past experience of mothers (34%) were the reasons for performing the practices. Mothers are not aware of the effect of female genital mutilation (69%), traditional uvulectomy (67.8%), dauri (herbal) bath and administration (50.5%). The common harmful cultural practices performed by mothers in Igabi LGA of Kaduna State include female genital mutilation (68.3%), traditional uvulectomy (63.6%), the use of dauri (herbal) bath and administration (54.4%). The result also showed that at $p= 0.05$ level of significance there was a

significant relationship between mothers age $p=$ (0.05), ethnic group $p=$ (0.02) and cultural beliefs of mothers. It also revealed that there was a significant relationship between cultural practices and marital status $p=$ (0.005), ethnic group $p=$ (0.018), family income $p=$ (0.056), parity $p=$ (0.025), number of children alive $p=$ (0.015) and place of delivery of mothers $p=$ (0.003). On the basis of the result and the objectives of the study, it was recommended that more attention should be given on harmful cultural practices by community health nurses in changing mothers' opinion regarding cultural neonatal feeding and illness. There is need for community health workers to educate the mothers more on early neonatal care especially on feeding practices and care during illness, not only when they go for antenatal care, but also in the form of campaigns, at market places, places of worship and social centers. Men should equally not be left out as they are the decision makers in the family. These will change their beliefs on neonatal care which will improve neonatal health and reduce neonatal morbidity and mortality.

Key words: Culture, Belief, Practices, Neonatal Health, Mother.

Table of Contents

Flyer Page	ii
Title	iii
Declaration	iv
Certification	v
Acknowledgement	vi
Abstract	vii
Table of Contents	ix
List of Figures	xiii
List of Tables	xiv
List of Appendices	xv
Abbreviations	xvi
Operational Definition of Term	xvii
CHAPTER ONE:	
1.0 INTRODUCTION	
1.1 Background of the Study	1
1.2 Statement of Problem	7
1.3 Research Objectives	8
1.4 Resaerch Questions	9
1.5 Significance of the Study	9
1.6 Scope of the Study	10

CHAPTER TWO:

LITERATUREREVIEW

2.1	Introduction	11
2.2	Culture, Beliefs and Practices on Neonatal Care	11
2.2.1	Some of the positive cultural practices that promote health amongst neonates	
2.2.2	Some Negative Cultural Practices that affect neonate and mothers health	
2.3	Reasons for performing Cultural Practice on Neonate	16
2.3.1	Information constraints	
2.3.2	Social constraints	
2.3.3	Cultural constraint	
2.3.4	Economic constraint	
2.4	Common Harmful Cultural Practices on Neonate	19
2.4.2	Pregnancy/Childbirths - delivery, the newborn, cord and placenta	
2.4.3	Infant feeding	
2.4.4	Diseases – causes and treatment	
2.4.5	Child rearing	
2.4.6	Categories of Traditional Healers	
2.5	Awareness about Harmful Cultural Practices on Neonate	26
2.6	National Intervention to Reduce Neonatal/Infant Morbidity and Mortality Rate	27
2.6.1	Delivery Care Practices	
2.7	The Role of Community Health Nurses towards Increasing Mothers Awareness about Hamrful Cultural Practices	36
2.8	Empirical Study	37

2.9	Theoretical Frame Work	48
2.9.1	Core Assumptions and Statements	
2.9.2	Theoretical Constructs	
2.9.3	Application of Health Belief Model to the Study	
2.10	Summary of the chapter	55

CHAPTER THREE:

MATERIAL AND METHODS

3.1	Introduction	57
3.2	Design	57
3.3	Area of Study/ Setting	57
3.4	Target Population	58
3.5	Sample Size	58
3.6	Sampling Technique	59
3.7	Tools and Instrument	64
3.8	Validity of the Tool	65
3.9	Ethical Considerations	65
3.10	Procedure for Data Collection	66
3.11	Procedure for Data Analysis	67
3.12	Limitations	67

CHAPTER FOUR:

RESULTS

4.1	Introduction	68
4.2	Descriptive Statistics	69
4.3	Inferential Statistics	85

CHAPTER FIVE:

DISCUSSION

5.1	Introduction	87
5.2	Discussion	88

CHAPTER SIX:

SUMMARY, CONCLUSIONS AND RECOMMENDATION

6.1	Summary	102
6.2	Conclusion	103
6.3	Recommendations	104
6.4	Suggestion for Further Studies	105

REFERENCES	106
-------------------	------------

APPENDICES	113
-------------------	------------

List of Figures

Fig 2.1 Health Belief Model	52
Fig 2.2 Application of Health Belief Model	55
Fig 4.1 Summary of the mothers opinion	81

List of Table

Table 3.1: Igabi Local Government Wards, Target Population and Selected Wards	63
Table 3.2: Selected Wards, Target Population and Sample size	64
Table 4.1: Socio-demographic characteristics of mothers	69
Table 4.2: Mothers current obstetric history	71
Table 4.3: Mothers opinion about culture and belief on neonatal care	73
Table 4.4: Mothers cultural practices regarding neonatal bath	74
Table 4.5: Mothers cultural practices regarding neonatal feeding	75
Table 4.6: Mothers cultural practices regarding umbilical cord care	76
Table 4.7: Mothers cultural practices regarding neonatal sickness	77
Table 4.8: Mothers cultural practices on the care of the neonate eyes	78
Table 4.9: Mothers cultural practices on surgical procedures on neonate health	79
Table 4.10: Summary of mothers opinion on cultural practices on neonate	80
Table 4.11: Mothers reasons of cultural practices on neonate care	82
Table 4.12: Mothers awareness about the effect of harmful cultural practice on neonatal health	83
Table 4.13: Common harmful cultural practices on neonate health	84
Table 4.14: The significant Relationship between Sociodemographic Characteristics of Mothers and Cultural Belief on neonate	85
Table 4.15: The significant Relationship between Sociodemographic Characteristics of Mothers and Cultural Practices on neonate	86

List of Appendices

1.	Questionnaire	113
2.	Igabi Local Government and Wards Population according to Primary Health Centers	121
3.	Letter of Introduction	123
4.	Ethical Clearance	124
5.	Informed Consent Form	125

Abbreviations

1. AIDS – Acquired Immune Deficiency Syndrome
2. ANC- Ante-natal Care
3. ASHAs - Accredited Social Health Activists
4. BCG - Bacilli Calmette-Guerin
5. CBOs - Community-Based Organizations
6. FGM – Female Genital Mutilation
7. FGD – Focus Group Discussion
8. FMOH – Federal Ministry of Health
9. HBM – Health Belief Model
10. HBV - Hepatitis B virus
11. HIV – Human Immunodeficiency Virus
12. IMNCI - Integrated Management of Neonatal and Childhood Illness
13. LGA – Local Government Area
14. NAYRHS – National Association of Youth and Reproductive Health Service
15. NDHS – Nigeria Demographic Health Survey
16. NRHM - National Rural Health Mission
17. OPV - Oral Poliovirus vaccine
18. PHCC – Primary Health Care Center
19. TU - Traditional Uvulectomy
20. TBAs – Traditional Birth Attendants
21. VDCs - Village Development committees
22. WHO – World Health Organization

Operational Definition of Terms

AWARENESS: Having knowledge about the harmful cultural practices of mothers on neonate.

BELIEF: Belief is when someone thinks something is reality or true and he or she agreed with it or its actions.

CULTURE: Culture is the collective term to identify the ideas, customs and social behavior of a particular people or society

CULTURAL PRACTICE: Cultural practices are the customary way which cultural activities are conducted. They are usually transfer from generations to generations.

HARMFUL CULTURAL PRACTICES: are those customs that are known to have adverse effects on the neonate's health

MOTHERS; Nursing mothers who are currently breast feeding or who had nursed a baby not more than one year

NEONATE: A child from birth to the first month of life

NEONATAL HEALTH: Is the wellbeing of a newborn baby within the first month of life.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Culture is derived from a French term which in turns derived from the Latin “colere”, which means to tend the earth and grow, or cultivation and nurture. Culture is the characteristics and knowledge of a particular group defined by everything from language, religion, social habits etc. (Kim, 2015). The Center for Advance Research on Language Acquisition CARLA (2014) defines culture as shared patterns of behavior and interactions, cognitive constructs and understanding that are learned by socialization. Thus, it can be seen as the growth of a group identity fostered by social healthy patterns unique to the group. Culture is also dynamic and evolving, learned and passed on through generations, shared among those who agree on the way they name and understand reality, often identified ‘symbolically’, through language, dress, music, health behaviors, and integrated into all aspects of individuals’ life (Nova, 2005). Abasiokong (2010) stated that culture “is that complex whole which includes knowledge, belief, art, morals, law, customs and any other capabilities and habits acquired by man as a member of the society”.

There are various cultural practices followed which affect the neonate, a family which mirrors value, traditions, customs and beliefs, i.e. culture of a society to which it belongs, plays an important role in physical, psychological, social development and health on neonate (Reshma and Sujatha, 2014). Cultures are also protected by taboos, which are strong social prohibitions (or bans) and are relating to human activity or social custom based on moral judgment and religious beliefs. This means that cultures are not easy to

change, because people adhere to these patterns of behaviour, believing that they are the right things to do (Adolescent and Youth Reproductive Health, 2005).

Belief is a mental representation of an attitude positively oriented towards the likelihood of something being true (Schwitzgebel, 2006). In the context of Ancient Greek thought, two related concepts were identified with regards to the concept of belief; these are the *pistis* and *doxa*. *Pistis* refers to trust and confidence, while *doxa* refers to opinion and acceptance (Leicester, 2008). The beliefs that influence health behaviors in most people are often carried in their culture's folktales and passed down over centuries through family health and healing practices regardless of race or ethnic origin Abdulaziz, (2009).

Cultural beliefs not only shape how individuals respond to forms of health and illness but also choices about which forms of care should be accessed. For example, cultural beliefs about certain forms of disease may lead to silence and denial thus creating veritable grounds for the continuation of behaviors and actions that promote the disease (Onyeabochukwu, 2007). Cultural practices consist of the beliefs and practices held or observed through their grand-parents, parents and the society around them (Quizlet, 2017). Cultural practices are also long-established patterns of actions or behaviors, often handed down within a community over many generations (National Adolescent and Youth Reproductive Health Services, 2007 and Federal Ministry of Health, 2005). So therefore, all people, no matter the race, have their own beliefs and practices concerning health and disease (Onyeabochichuku, 2007).

Each society or community has its peculiar way of doing their culture practices and it is known that these practices and beliefs go a long way in influencing the people's perception, attitude and management of diseases and other health related problems that

befall them (Onyeabochichuku, 2007). Some of these cultural practices, which have endured centuries of practice, have worked for the people who practice them. Not all cultural / traditional practices are harmful. Some have stood the test of time and have positive values, while others may be harmless, uncertain or negatively harmful (Uzobo, Ogbanga and Jack, 2014).

African continent is one of the largest continents of the world and it's a multi-ethnic society with its peculiar nature and diverse practices (Ojua and Omono, 2012). Also Nigeria as a country is made up of people from different ethnic groups with the dominant groups being Igbos, Yorubas and Hausas. It has more than 250 ethnic groups with different cultural practices (Idehen, 2007). Therefore, Nigeria over the years is considered one of the largest and most populous nations of Africa, which also harbor's different ethnic groups and endures different operation of cultural practices (Idehen, 2007). More so, the way of life of the people can determine their development over time in all ramifications as compared to global growth and societal development.

Neonatal health and survival depend on the care given to the newborn, which is an essential element in reducing neonatal mortality (Yinger and Ransom, 2003). Current global estimates place the annual neonatal death toll at 4 million (Save the Children, 2001). It is estimated also that 60 percent of newborn deaths occur on the first days of delivery. The average neonatal mortality rate in developing countries is over eight times (33/1000 live births) than what is prevailing in developed countries (4/1000 live births) (Parlato, Darmstadt and Tinker, 2004). The greatest risk of childhood death occurs during the neonatal period, which extends from birth through the first month of life (Yinger and Ransom, 2003). The risk of neonatal death is highest in Africa with the sub-Saharan

African regions of Eastern, Western and Central Africa having between 42 and 49 neonatal deaths/1000 live births respectively (World Health Organization, 2006). This is closely followed by South-Central Africa with 43 neonatal deaths/1000 live births, whereas the neonatal mortality rate for Latin America and the Caribbean is 15/1000 live births (World Health Organization, 2006). The neonatal mortality rate (NMR) in Ghana is 43 per 1000 live births (GSS, NMIMR and ORC Macro, 2004).

Neonatal period is a period when a child's risk of death is nearly 15 times greater than at any other time before the first birthday (Yinger and Ransom, 2003).

The Nigeria Demographic and Health Survey (NDHS, 2013) estimated its Neonatal Mortality Rate (NMR) as 37 per 1000 live births which constituted about 54% of infant mortality. The burden of neonatal mortality in Nigeria was higher than that of the African region as a whole in 2009 (36 per 1000) (Oesterggaard, Inoue, Yoshida, Mahanani, Gore and Cousens, 2009). Many factors account for this high NMR and these include household practices such as inappropriate cord care, bathing babies immediately after delivery, socio-cultural beliefs and practices (Oesterggaard et al., 2009).

Therefore, cultural practices cannot be neglected when considering the achievement of better neonatal care in developing countries. This is because most deliveries occur at home and health services may not be available (World Health Organization, 2006), even the babies delivered in hospitals may be affected by traditional practices after discharge and these practices have a major impact on neonatal morbidity and mortality patterns (World Health Organization, 2006). Most traditionally-oriented parents may be unwilling to move ill newborn babies from home because of cultural beliefs such as the fear of people with 'bad eyes' transmitting sicknesses to the newborn when they see it.

Therefore, the fact that the newborn is not yet considered a human being, parents/caretakers shouldn't expose them too early to practical difficulties (World Health Organization, 2006).

National Adolescent and Youth Reproductive Health Service and Federal Ministry of Health, (2007) stated that there are many factors responsible for cultural practices which may be educational status (Level of education of mothers), customs, lifestyles and values that characterize a society or group. The cultural aspects include concepts of education, language, law and politics, religion, social organizations, technology and material culture, values and attitudes (National Adolescent and Youth Reproductive Health Service and Federal Ministry of Health, 2007). So also the social factors may include reference groups, family, role and status in society, time and available resources (National Adolescent and Youth Reproductive Health Service and Federal Ministry of Health, 2007).

The complications of Female Genital Mutilation on neonate are severe lacerations and bleeding, while the wound may heal with complications like, fibrosis, scar formation and eventual narrowing of the vaginal orifice. Infections like tetanus may set in from the use of unsterilized surgical tools and unhygienic environment (Gbefwi, 2004). It is also a common practice in our society for a pregnant woman to register in the antenatal clinic and also with the traditional midwife in the community (Gbefwi, 2004). During delivery, however, she goes to the traditional midwife to have her baby. In the course of the delivery with unsterilized instruments, coupled with lack of adequate knowledge on how to take deliveries, and poor management, the baby may develop conditions like bleeding,

infection or injury to the baby, or may die due to the above attendant consequences (Gbefwi, 2004).

Community health nurse therefore has an essential role to play in assessing health care by increasing mothers awareness about harmful Practice which is one of the intervention strategy to minimize and eliminate harmful cultural practices among mothers. When raising awareness the nurse should target everyone in the community especially young people, men, community leaders, religious leaders and the women who perform the harmful cultural practices. In particular, the nurse needs to work with both Islamic and Christian religious leaders as some of the justifications for practicing harmful traditional practices are incorrectly linked to religions. Most religious leaders teach their followers about the position of their religion with regard to such practices which will help in educating the community. It is crucial that the nurse should attempt to educate the traditional practitioners of harmful cultural practices about the dangers of such practices (National Adolescent and Youth Reproductive Health Service and Federal Ministry of Health, 2007). It is important to use educational activities to address the community's perceptions that there are disadvantages to practicing harmful cultural practices. This can often be done effectively by describing a case study of harmful cultural practices; the nurse should help by listening in a sympathetic and non-judgmental way. There may also be some medical assistance the nurse can offer, but there is the need to refer them to the next level of facility for better psychosocial support and medical assistance.

1.2 Statement of the Problem

Neonatal period is a time of transition and social celebration in many societies, signaling an adjustment of cultural responsibilities. Women's progression from birth to childrearing is influenced by economy, religion, kinship system and the growing sophistication of communications and medical technology (Joannah, Qiyan, Rachel, Tolhurst and Paul, 2007). In some societies, there is a continuum between traditional and modern care, with some households operating at the traditional end, others at the modern end, with majority somewhere in between (Joannah, et al, 2007).

Harmful cultural practices are those customs that are known to have negative effects on neonate's health. The practice is based on tradition, culture, religion or superstition and are often perpetrated against the neonate, who are clearly lacking the capacity to consent or to refuse to consent themselves (Gebrekirstos, Atsede and Buruh, 2013). The greatest gap in the neonate care is often during the critical first week of life when most neonatal and maternal deaths often occur at home and without any contact with the formal health sector. Some unacceptable practices such as unskilled attendants during delivery, unhygienic delivery practices, taboos and superstitions associated with caring for the newborn greatly affect newborn survival (Marah, 2011). Mothers who are inclined to traditional beliefs and practices in the community greatly influenced young mothers of neonates in using all sorts of herbs and other concoctions in either treating sick neonates or protecting the newborn from becoming ill (Marah, 2011).

In rural areas of Nigeria, the proportion of institutional deliveries is as low as four percent. Even in urban areas like Lagos, a significant proportion of women (19%) still deliver at home (Lamina, 2011). In Kaduna State, the neonatal mortality rate per 10000

live births is 114 and the annual number of neonatal deaths is 12,300 (Nigerian Demographic Health Survey, 2013).

As a community health nurse understanding health cultural factors that affect the physical health and being sensitive to these factors can make an important difference in health outcome. Beliefs affect how and from whom a person will seek care, how care is managed, how health choices are made, how the individual response to health education, all these are essential roles of community health nurses. These factors motivated the researcher to go into the community and explore how the cultural practices and beliefs of mothers can affect the community health.

Therefore the aim of this study was to explore the cultural practices and beliefs of mothers towards neonatal health in Igabi LGA of Kaduna State.

1.3 Objectives of the Study

The aim of this study was achieved through the following objectives:

- To explore opinions about cultural practices of mothers towards neonatal health in Igabi LGA of Kaduna State
- To explore the reasons for the cultural practices of mothers on neonate in Igabi LGA of Kaduna State
- To identify the common harmful cultural practices of mothers on neonate in Igabi LGA of Kaduna State
- To determine mothers awareness about the effects of harmful cultural practices towards neonatal health in Igabi LGA of Kaduna State

1.4 Research Questions

- What is the opinion about cultural practices of motherstowards neonatal health in Igabi LGA of Kaduna State?
- What are the reasons for cultural practices of mothers on neonatein Igabi LGA of Kaduna State?
- What are the common harmful cultural practices of mothers on neonate in Igabi LGA of Kaduna State?
- What is the mothers' awareness about the effect of harmful cultural practices towards neonatal healthin Igabi LGA of Kaduna State?

1.5 Significance of the Study

The research study was focused on Cultural Beliefs and Practices of mothers towardsneonatal health in Igabi LGA of Kaduna State. Expectedly the outcome of this study will be significant in the following respects:

Mothers: The findings of this study will expose the positive and negative cultural practices of mothers on neonatalhealth, where positive ones will be encouraged and the negative ones will be discouraged. Mothers will benefit through creation of awareness in understanding the negative effect of harmful cultural practices. These will go a long reducing neonatal mortality.

Neonate: Neonatal health status will be improved and modified through health talks, community outreaches, home visits, effective ante-natal care visits, delivery and post-natal care by promoting the positive cultural behaviour and discouraging the negative ones. As such, Neonatal illness (morbidity) and mortality will be reduced.

Community: The community will be enlightened through creating workshops, health talks, outreaches etc. It will reduce the economic burden of illness attributed to cultural practices on neonate. Community-based volunteers will be encouraged to train and give the necessary skills to ensure that the needs of neonates and their mothers are met.

HealthWorkers: This information will be relevant to health care providers on how to identify health problems related to cultural practices on neonatal health. Therefore, this study will provide a base line data for the health worker for further studies on cultural practices and beliefs on neonatal health.

Government/ PolicyMakers: The findings will also be important to health policy makers/ government in designing policies and to translate the knowledge into effective policies and programs in different settings pertaining to neonatal health and survival.

1.6 Scope of the Study

This study is delimited to the cultural beliefs and practices of motherstowards neonatal health in Igabi L.G.A of Kaduna State, Nigeria.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter presents available literatures for the study. The chapter will cover the following sections:

Conceptual Review

- Culture, Beliefs and Practices of Mothers on Neonatal Health
- Reasons for performing Cultural Practices of Mothers on Neonate
- Awareness of mothers about the effect of harmful cultural practices on neonatal health
- Common Harmful Cultural Practices by Mothers on Neonate
- National policy on neonatal health
- The role of nurses towards increasing mothers awareness about harmful Practice
- Emperical studies
- Theoretical Frame Work
- Summary of reviewed Literature

Conceptual Review

2.2 Culture, Beliefs and Practices by Mothers on Neonatal Health

Culture is the collective term to identify the ideas, customs and social behavior of a particular people or society (Marshall, 2007). It can be a way of life built up by a group of people. Taylor, the founder of cultural anthropology defines culture as “complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society” (Marshall, 2007). Some

aspects of human behavior, such as language, expressive forms such as ritual, religion, art, music, dance and practices such as cooking, shelter, and clothing are found in all human societies (Marshall, 2007). However, these practices differ according to different ethnicities, nationalities, and even different age groups (Marshall, 2007). For example, the difference between dance forms in India and dance forms in China is a result of the difference in ethnicity and nationality (Marshall, 2007).

The term culture can refer to a variety of concepts. For example, food is eaten by a particular group of people (ingredients: coconuts, ghee, wheat flour, etc.), how that food is prepared (methods: baking, boiling, raw, etc) and what are the customs associated with eating (use of chopsticks, men and women don't sit at the same table, etc) (Marshall, 2007). Culture is a social phenomenon, and a behavior of a particular individual which is shaped by the culture (Marshall, 2007).

Cultural Practice is also the customary way which cultural activities are conducted (Gbefwi, 2004). It is the mode or pattern by which customs and taboos are upheld on one hand and cultural activities implemented on the other hand (Gbefwi, 2004). Traditional/Cultural Practice plays an important role in the field of health, especially in developing countries. Each community has its own special beliefs about the causes of diseases, modes of transmission and ways of treatment (Gbefwi, 2004). What a community believes about health and ill- health helps it to decide what to do. Traditional practice may have negative or positive effect on health and how they use health services, while others make no difference to health (Gbefwi, 2004).

“Belief is the state or habit of mind in which trust or confidence is placed in some person or thing. It also something that is accepted and considered to be true or held as an opinion

(Merriam Weber dictionary, 1828). In other words, “belief is when someone thinks something is reality, true, when they have no absolute verified foundation for their certainty of the truth or realness of something”.

Cultural and traditional practices, values and beliefs play an important role in the medical attention-seeking behavior of postpartum mothers as well as in newborn babies during the postnatal period (Reshma and Sujatha, 2014). There are various traditional and cultural practices followed which affect the newborn. A family which mirrors value, traditions, customs and beliefs, i.e. culture of a society to which it belongs, plays an important role in physical, psychological, social development and health in children. Newborn mortality is one of the world's neglected health area (Reshma and Sujatha, 2014). As most of births and deaths occur outside any established health care facility, reduction in neonatal mortality may depend significantly on interventions involving promotion or adaptation of traditional care behaviors practiced in the home. Feeding of colostrum, timing of initiation and duration of breastfeeding, umbilical cord care, and measures taken to prevent hypothermia of the newborn are important factors in health and survival during the neonatal period (Reshma and Sujatha, 2014).

The healthy new born infant born at term, between 38 to 42 weeks,cries immediately after birth. The period from birth to 28 days of life called neonatal period and the infant in this period is termed as neonate or new born baby(Panul, 2007).The neonates are at risk for various health problems even though they were born with average weight. The morbidity and mortality rate in new born infants is high, they need optimal care for improved survival(Panul, 2007).

The normal term baby weighs approximately 3.5 kg, when fully extended measures 50 cm from the crown of the head to the heels, head circumference of 34-35 cms. Vernix caseosa is a white substance present on the baby's skin at birth. It is thought to have a protective function in utero and after birth drive up and flakes off within a few hours.

Neonatal care is caring for the normal baby to ensure that the baby is made comfortable, feed and that facilities are available for the parents to help them with the attachment process and also important to ensure that the baby is protected from airway obstruction, hypothermia, injury and accident infections(Mayles, 2003).

The mothers who are not equipped with sufficient knowledge about newborn care and using traditional child care methods may sometimes cause harm to their newborn and even cause handicaps in them (Reshma and Sujatha, 2014).

2.2.1 Some of The Positive Cultural Practices that Promote Health Amongst Neonates and Mothers are;

1. It is common practice for women who just delivered to be placed on special diets. This they believe helps the woman to regain lost nutrients during pregnancy and delivery and this really goes a long way in promoting the wellbeing of the neonate (Idehen, 2007) .
2. Sexual abstinence during lactation is also widely practiced because of the belief that a woman is not fully pure at this time. This practice helps in child-spacing and family planning (Idehen, 2007).
3. Environmental Sanitation: This is practiced virtually in every Nigerian society. Early morning sweeping of the house and compound by both men and women is encouraged to promote the health of both the neonate and the mother (Idehen, 2007).
4. In Efik and Ibibio culture, it is a common practice for mothers to breastfeed their babies for a long time. This is a good practice as breast milk is far better than any other food a

child can receive within the first six (6) months to one (1) year and this acts as family planning to the mother (Idehen, 2007).

2.2.2 Some Negative Cultural Practices that affect neonate and mothers health include;

1. In the Southern part of the country during circumcision of the neonate, it is a common practice to use cowdung to clear the umbilical cord. This results in tetanus infection caused by a bacterium called “clostridium tetani (Ojua, Ishor and Ndom 2013).
2. In a typical Nigerian rural society, there are cultural beliefs that children are usually not given foods like egg, meat etc for fear that they will become thieves, witches/wizards. This leads to a condition of kwashiorkor which is as a result of lack of protein in the system (Ojua et al, 2013).
3. Female and male circumcision is practiced not only in Nigeria but also in at least 26 countries of Africa (Ojua et al, 2013).
4. Scarification and tribal marks are practiced commonly all over Nigeria but especially in the Southwest and Northern part of Nigeria (Ojua et al, 2013).
5. Cutting of uvula (Traditional uvulectomy); The cutting of the uvula is widely practiced, it is believed that it can protect the patient from various infections of the pharynx and the respiratory system (Adesina, 2013).
6. Forced feeding of babies. This may result to suffocation and even death of the babies (Gbefwi, 2004).
7. Use of herbal concoctions on neonate. Though some herbal drugs may be good but the fact that many lack dosages is a major challenge. Also some in addition to the good part contain other toxins which can damage major organs like liver, kidneys etc.

2.3 Reasons for performing Cultural Practice on Neonate

Nigerian Demographic and Health Survey, (2013) stated that according to specific reasons cited for not delivering in health facility in Nigeria was that overall, 33% of mothers reported that they did not give birth at a health facility because the child was born suddenly and there was no time to reach the facility. The findings indicated that 29% of women did not deliver in a health facility because they felt it was not necessary, while others reported distance from the facility (13%) or cost (8%) as the main hindering factor. In the case of sixth- and higher-order births, the reason most often cited was that it was not necessary to deliver at a health facility (31%) (Nigerian Demographic and Health Survey, (2013).

Reasons varied across zones. Cost was cited as the greatest impediment to delivery at a health facility in the South South zone (27%). Mothers in the South West 7% cited lack of trust for the provider or poor quality of service as their reason for not delivering in a health facility. The South West also had the greatest proportion of women whose husbands or family did not allow them to deliver in a health facility (12%). The North West had the highest proportion of mothers who said that delivery in a health facility was not necessary (37%) (NDHS, 2013). Twelve percent of mothers in the North West said that it is not customary to deliver in a health facility. One of the most cited reasons for not delivering in a health facility in all of the zones other than the North West and South South was that the child was born suddenly and there was no time to reach the facility. 44% of mothers in the North East cited this as a reason for delivering at home, along with 41 percent in the North Central zone, 37% in the South East, and 26% in the South West. This is particularly important because it may reflect the need for

improvements in the quality of antenatal care received. It is during ANC visits that the expected date of delivery is typically determined. The mother is usually expected to deliver any moment from 38-42 weeks of gestation. Errors in estimating the expected date of delivery could lead to the baby being delivered supposedly unexpectedly (Nigerian Demographic and Health Survey, 2013).

In another context by WHO, (2002) the level of social and economic development, the quality of health services, the environmental circumstances as well as cultural practices are some of the reasons behind cultural practices. The socio-economic factors that affect access to health care cause maternal and neonatal mortality which operates at the individual, family and community level. Women make decisions about their health depending on their educational level, occupation, level of personal income or wealth and their autonomy. The aggregate family income, occupation and education of family members could also affect access to health care for the woman and her newborn baby. With the community, the collective resources and wealth plays an important role in the socio-economic aspects of the health needs of community members (McCarthy and Maine, 1992).

2.3.1 Informational constraints

Refers to constraints in knowledge such as the clients' lack of information regarding current recommended essential newborn care practices and their health outcomes, that is, a major reason for not adopting a new practice could simply be lack of knowledge and a sound understanding of its availability, use and benefits.

2.3.2 Social constraints

These are related to the social patterns in a community that discourage the adoption of essential newborn care practices, for instance, older relatives such as mothers-in-law in many traditional areas still have considerable say over decisions concerning pregnancy, birth and child care, whereas their influence may be weaker in modern urban communities, the influence of the media may be rather stronger.

2.3.3 Cultural constraint

An example of a cultural constraint would be that, husbands in more traditional areas may dictate their wives' activities but this may be minimal or absent in some urban areas where women have greater independence and education.

Religious beliefs which are also cultural constrain everywhere, quest for health easily shades into issues of morality and religion which play a significant aspect of social life. The basic explanation is that in serious illness there is an underpinning of the supernatural, the most frequently evoked agency is ancestral spirit anger (Ojua and Omono, 2012). Ancestral spirit constitutes part of the ordered structure of the African religion. People believe that upsetting the ancestors produces a disturbance of this order and hence disharmony and illness occur. In African thoughts, all living things including man are linked in harmonious relationship with the gods and the spirits, such relationship is ascribed to vital forces which each entity generates. A state of health exists when there is perfect harmony between man and his environment (Abia, 2012). This belief is inherent in those who practice African traditional religion as well as in many Christians and Muslims(Omosho, 2010). Religious practices at one point in time or the other ill-health and other misfortunes, which often times defile scientific and orthodox treatments

are explained as spiritual forces directed by witches, wizards, sorcerers, evil spirits or angered ancestors (Ojua and Omono, 2012).

2.3.5 Economic constraint.

The economic constraint would be the unavailability of cash to pay for essential newborn care services (Parlato et al., 2004).

2.4 Common Harmful Cultural Practices on Neonatal Health

Common harmful cultural Practices are classified into 4 categories (Nairaland, 2013)

Pregnancy/Childbirths - delivery, the newborn, cord and placenta

Infant feeding

Diseases – causes and treatment

Child rearing

2.4.1. Pregnancy/Childbirths/Newborns

1. Restriction of certain foods from pregnant women or lactating mothers/ food taboos. The pregnant woman or lactating mother is to eat a balanced diet at all times and there is no need for any food restriction except for medical reasons e.g. among the diabetics or hypertensive.
2. Application of heat, cow dung, dusting powder, toothpaste etc on the umbilical cord of newborns. There are situations in some communities where cow dung is used on the baby's cord to hasten the fall of the umbilical cord. The practice is observed among some Yoruba ethnic groups of western Nigeria. The harmful effect is that infections like tetanus and septicemia may set in, claiming the baby's life, thus increasing neonatal death rates (Gbefwi, 2004). All these can lead to cord infection and/or neonatal tetanus

3. Throwing away of the milk in the first few days of life known as colostrum, erroneously believed to be 'sour' or bad because of its light yellow colour. Yet this is the best milk that is full of antibodies that protect the baby against so many diseases (Nairaland, 2013).
4. Squeezing the 'swollen breasts' of the newborn to express the milk, this results in breast infection and abscess.
5. Application of sticky substances on the anterior fontanelle of the baby. The anterior fontanelle is that part of the baby's head that seems to be pulsating and very soft. Some people call it 'oka'. It is a normal part of the head that allows for the brain to grow and it will eventually close by itself by age of 2 years.
6. Ajogba/local pharmacy – due to beliefs that newborns must always take medications including antibiotics, multivitamins, neospamin, gripe water, baby paracetamol etc. The truth is that they need none except vitamin drops.
7. Antenatal Clinic Attendance but Home Delivery: It is a common practice in our society for a pregnant woman to register in the antenatal clinic and also with the traditional midwife in the community. During delivery, however, she goes to the traditional midwife to have her baby. In the course of the delivery with unsterilized instruments, coupled with lack of adequate knowledge on how to take deliveries, and poor management, the baby or mother may develop conditions such as lacerations, postpartum bleeding, infection or injury to the baby, or may die due to attendant consequences (Gbefwi, 2004).

2.4.2 Infant Feeding

1. Modern practice by some ladies to avoid breast feeding their children for reason as maintaining sex appeal and that's what acceptable in developed climes.
2. Early introduction of solids before age of 6months. Some mothers even gave baby pap from the first month of life. Their digestive system is not yet ready to deal with solid before age 4-6months.
3. Forced feeding of babies 'riro omo lounje'. The mother places her child (lying down) across her lap and cups her palm under the child's mouth (lower and upper lips); partially or totally closing the nostrils with the last finger only, releasing the finger at intervals as the child gulps down the liquid food which could be gruel, pap or even water (Gbefwi, 2004). This is a general practice in many ethnic groups in Nigeria (Gbefwi, 2004). Mothers are not patient enough to use cup and spoon to feed their children. During this ordeal, the child struggles for air. It is an unhealthy feeding practice because it leads to overfeeding, inhalation of feeds and suffocation. The complication includes difficulty in breathing; vomiting and it could subsequently leads to upper respiratory tract infection and possibly pneumonia (Gbefwi, 2004). This can lead to choking on feeds and we have had babies dying from forced feeding (Gbefwi, 2004).

2.4.3 Diseases – Causes and Treatment

1. Application of scarifications marks for treatment of conditions like constipation, abdominal swelling or for beauty or identification. The latter is actually a criminal offence in the Child Rights Act. The scarifications can lead to diseases like Tetanus, transmission of HIV (Nairaland, 2013).

2. Female Circumcision: This is practiced in some communities in Nigeria and other African countries, especially at puberty or in the second trimester of pregnancy. It is common among some ethnic groups in Nigeria, and the percentage of practice is high in some state like; Ondo (90- 98%), Delta (80- 90%), Plateau/Nasarawa (30- 90%), Kebbi (90- 100%), and Borno (10- 90%) (Gbefwi,2004). Female circumcision is the excision of the genitalia. The excision of the genital could range from just removing the prepuce, to removing the hooded clitoris together with partial or total excision of the labia minora.at times it may include part of the external genitalia. Most of the circumcision is done at home (Gbefwi, 2004).

The main reason for the circumcision exercise, according to them, is to prevent promiscuity and to aid child delivery. The belief also is that, if the child's head touches the clitoris during labour, he/she will die or become a moron when he/she grows up (Gbefwi, 2004). The adverse effects of this absurd practice are severe lacerations and bleeding, while the wound may heal with complications like, fibrosis, scar formation and eventual narrowing of the vaginal orifice, difficult and painful coitus and delivery. Infections like tetanus may set in from the use of unsterilized surgical tools and the insanitary environment (Gbefwi, 2004). There may be loss of libido due to the interference or removal of the external genitalia. Complication of female circumcision could lead to wife neglect and broken marriages. However, a national survey on harmful and beneficial practices indicates a decline over the generations (Gbefwi, 2004).

3. Teething – use of teething Powder/syrups.

4. Diarrhoea – treating diarrhea with the following drugs flagyl, tetracycline, diastop, thalazole etc are very dangerous practices indeed. Also withholding food and drink in

neonate with diarrhea so as to stop the stooling is very dangerous and can lead to death if prolonged (Nairaland, 2013).

5. Convulsion – putting wood, spoon, knife etc in the mouth of a convulsing child is a dangerous practice that can damage the teeth or lips (Nairaland, 2013).
6. Use of herbal concoctions. All drugs are poisons; it is the dose that differentiates what is beneficial from what is dangerous. Though some herbal drugs may be good but the fact that many lack dosages is a major challenge. Also some in addition to the good part contain other toxins which can damage major organs like liver, kidneys etc. some from our experience has been associated with terrible complications (Nairaland, 2013).

2.4.4. Child Rearing

Avoidance of immunization - All children should be immunized. Some mothers because of some negative experience in the past either directly or indirectly decline their kids' immunization exposing those children to preventable diseases/deaths (Nairaland, 2013).

Traditional medicine, as it is well known, is a cultural practice of various communities around the world and encompasses all kind of folk medicine, unconventional medicine and indeed any kind of therapeutic method that have been handed down by the tradition of a community or ethnic group (Adesina, 2013). Traditional healer as defined by W.H.O, (1976), is a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background, as well as on the knowledge, attributes and beliefs that are prevalent in the community, regarding physical, mental and social well-being and the causation of disease and disability. Traditional healers compound health matters. Some traditional healers, after preparing some herbs or

concoctions for a patient take a little quantity of sand or soil and after incantations, throw it into the prepared herbs; the concoction is usually high in concentration and poor method of preparation. This is a way of spreading some diseases. Traditional medicine is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observations handed down from generation to generation whether verbally or in written (WHO, 1976).

2.4.5 Categories of Traditional Healers

Traditional surgeon-the various forms of surgery recognized in traditional medical care Adesina (2013) include:

1. **The Cutting of Tribal Marks:** traditional surgeons usually cut tribal marks into the cheeks, bellies, hands, necks and herbal product are usually into this bleeding marks to effect healing (Adesina,2013).
2. **Male and Female Circumcision:** traditional surgeon this simple surgical operation with special knives and scissors, blood-letting operations and wounds that result from these operations are usually treated with snail body fluid or pastes prepared from plants, these practices are, however, fast dvino out in urban areas (Adesina, 2013).
3. **Removal of Whitlow:** diseased toes or fingers are usually cut open and treated. Piercing of ear lobes: particularly in the youth to allow the fixing of air rings. Extraction of tooth: infected teeth or teeth with a hole that bring pain to the mouth are removed and treated with herbal medicines prepared in local gin. Performance of amputations: occasionally and very rarely too, there are amputations performed with ‘anesthesia’; usually, the

patient is sent to sleep with a strong narcotic concoction and the amputation done with a very sharp knife. The excision has to be achieved with the very first stroke. The stump is packed with a suitable herbal preparation and healing, usually occurs within some four or five weeks (Adesina, 2013).

4. Cutting of uvula (uvulectomy); the cutting of the uvula is widely practiced. It is believed that uvulectomy can protect the patient from various infections of the pharynx and the respiratory system. Traditional surgeons in the northern part of Nigeria are versed in cutting off the upper end of the throat flap commonly referred to as epiglottis for the treatment of many illnesses (Adesina, 2013).

The traditional surgeon performer has skill without the aid of X-rays and with only a little knowledge of anatomy. While he may still be respected in some local communities, complicated surgery is better achieved with modern facilities and better trained hands these days (Adesina, 2013).

5. Bones setters: bone setting or orthopedic surgery is the art of pairing fractures and other orthopedic injuries. It is recognized to have attained a level of success comparable to that in orthodox medicine in Nigeria. Traditional bone setters are those knowledgeable in the art and skill of setting broken bones in the traditional way, using their skill to see that bones unite and heal properly (Adesina, 2013).
6. Traditional Birth Attendants (TBA):

The World health organization defines a traditional birth attendant (TBA) as a person who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other birth attendants. In the northern parts of the country,

TBAs are of the female sex only, whereas in some other parts both males and females are involved.

2.5 Awareness about Harmful Cultural Practice on Neonate

Traditional practices have been found to dominate newborn care in developing countries (Devkot and Bhatta, 2011) While some of these practices may not have any harmful effect on health, others do (Ameh, 2002). Mothers not equipped with sufficient knowledge about child care who use traditional childcare methods may cause harm to their children's health (Beser et al, 2010). It is therefore recommended that these practices should be investigated; the useful ones should be preserved while the harmful ones should be discarded. There is an urgent need to educate mothers and other key family members on early neonatal care. The roles of community health actors such as mothers, mothers-in-law, husbands, and traditional birth attendants should be taken into consideration in intervention programmes. There is also need for intervention programmes like provision of health facilities in rural areas as well as employment of more health workers to man these facilities. The role of female education and poverty alleviation cannot be overemphasized.

Social-cognitive theory recognizes that interaction with people rather than the provision of information alone is the key to behaviour change especially if the latter conflicts with existing motives, beliefs and values (Seidel, 2005). The use of participatory health promotion techniques, such as women's groups, has proved very successful at reducing neonatal mortality elsewhere in South Asia, and assisting communities to find locally adapted solutions to problems (Manandhar et al., 2004).

Behaviour change messages need to be based on an understanding of the beliefs supporting traditional behaviour, and adapted and tailored to the specific environment. In understanding reactions to the essential newborn care package of interventions, the Innovation Diffusion theory is useful. It describes the process by which an innovation, new ideas, opinions, attitudes, and behaviours are communicated through certain channels over time, and spread among the members of a social system or community. Its five major assumptions are that: adoption takes time; people pass through various stages in the adoption process; they can modify the innovation and sometimes discontinue its use; the perceived characteristics of the innovation influence its adoption; and individual characteristics influence its adoption (Rogers, 1995). In encouraging and directing behaviour change existing views need to be engaged with respectfully, health workers cannot see the community as an empty vessels into which to impart education. Messages can be adapted so that proposed changes relate to existing health worries, for example building on the local concern about babies catching cold. Where examples of positive deviance are present, these can be highlighted and affirmed. Also in some circumstances appropriate compromises between existing and recommended practices can be suggested for areas of care met with particular resistance.

2.6 National Intervention to Reduce Neonatal/Infant Morbidity and Mortality Rate

Survival of the newborn is an issue of great concern especially for the developing world (Lawn et al, 2001). Care for the neonate often receives little attention in maternal and child health programmes. Though various efforts have been made by governments to reduce infant mortality, neonatal mortality keeps increasing. Of the approximately four

million global neonatal deaths that occur annually, 98 percent occur in developing countries, where most newborns die at home while they are cared for by mothers, relatives, and traditional birth attendants (WHO, 1996). Almost two-thirds of infant deaths occur in the first month of life, among those, more than two-thirds die in their first week and among those, two-thirds die in their first 24 hours after birth (Lawn et al, 2001). Improvement in the survival of the newborn is dependent on health care that spans antenatal, intra-natal and postnatal periods, i.e. interventions directed to mothers during pregnancy labour and delivery have a profound impact on newborn survival especially during the first week of life when three-fourths of neonatal mortality occurs. More so, improvements in the survival of the newborn includes the care given to women in the pregnancy period as for example; nutrition of young girls can have an impact on their adult height which in turn can influence outcomes for labour and delivery. Another example would be that the pregnancy folic acid status of the mother can determine the incidence of some congenital abnormalities. Maternal care is therefore not only important for reducing maternal mortality but also neonatal mortality. It is estimated that about 12 million pregnant women in Sub-Saharan Africa do not get tetanus immunization, however, the presence of a midwife, nurse or doctor at child birth in developed countries is taken for granted (Vinod, 2005). Households can be regarded as a nation's health production system, in that they produce health from the local community level to that of the wider society. Newborn care remains a neglected problem and this impacts negatively on MDG4 on child health which pledges 14 to reduce under 5 years mortality by the year 2015, however, the survival of humankind as a whole will be impossible without protecting maternal and newborn lives.

2.6.1 Delivery Care Practices

Immediate Newborn Care

There are marked variations in patterns of newborn care and interventions. Knowledge on what is needed for optimal newborn care is lacking in many cases. Modern hospital practices as well as traditional practices neglect the basic needs of newborns, these basic needs include: warmth, cleanliness, breast milk, safety and vigilance. Other interventions such as: thermal protection, breast-feeding, eye care (to reduce blindness), have essential preventive effects (WHO, 2006). The World Health Organization (WHO, 1996) recommends the following essential newborn care interventions:

- Clean childbirth and cord care in order to prevent infection
- Thermal protection in order to prevent and manage newborn hypo/hyperthermia
- Early and exclusive breastfeeding which should be started within 1 hour after child birth
- Initiation of breathing and resuscitation to facilitate early asphyxia identification and management
- Eye care for the prevention and management of ophthalmia neonatorum
- Immunization: at birth with Bacilli Calmette-Guerin (BCG) vaccine, Oral Poliovirus vaccine (OPV) and Hepatitis B virus (HBV) vaccine
- Identification and management of the sick newborn
- Care for the preterm and/or low birth weight newborn the study focused specifically on practices such as clean child birth, Early and exclusive breastfeeding, immunization of BCG and OPV, recognition and management of the sick newborn.

Clean Childbirth

Newborns are more likely to survive if delivery is clean, that is if actions are taken to help prevent infection. Ensuring a clean delivery implies that all those attending to the mother and newborn wash their hands with soap and water before during and after delivery. The perineal area of the vagina is washed before each examination and before delivery, and no foreign material is introduced into the vagina (the examiner's hand only when necessary). Delivery surface is clean, or at a minimum, birth doesn't occur on the bare floor (Parlato et al., 2004). In Pakistan, though respondents knew about the benefits of clean delivery, they rarely practiced it, more so, good knowledge and practices for maintaining the newborn's warmth were predominant, while delayed initiation of breastfeeding, avoidance of colostrum and prelacteal feeding were also common. Unhygienic cord care, including an unclean cut and application of ghee (black cosmetic powder) on the cord-stump, was the norm. Knowledge of some danger signs in newborns was common, but timely action upon recognition was not provided (Yadav, 2007).

Drying and Warming

Parlato et al. (2004), share the view that newborns regulate their body temperature much less efficiently than the adult and they lose heat more easily especially from the head. In agreement with the WHO (1996), they therefore recommend that, newborns should be thoroughly dried immediately after delivery and kept warm, the newborn should be thoroughly dried with clean towel as soon as the head and body are delivered in order to prevent hypothermia, this also helps in limiting the loss of body heat, and the stimulation produced could promote breathing and aid an asphyxiated newborn. It is also recommended that bathing should be delayed to between four to six hours after birth

(WHO 1996). However in Pakistan, it was observed that dais (traditional birth attendants) leave newborns unattended to, sometimes on the floor or ground, until the placenta is delivered, then the babies are washed with warm water and soap 1-2 hours after delivery. Dais hardly only wipes babies with dump cloth (Khadduri, et al., 2007). Another study in Nepal reports that newborn babies are considered dirty since they came out of their mother's womb, so almost all newborn babies are bathed within the first hour of birth (Yadav, 2007). The WHO also recommends that newborns should be observed for crying and breathing immediately after delivery and asphyxiated newborns should be recognized and resuscitated, and that newborns should be breastfed within one hour and should only be fed on breast milk.

Cord Care

There should be clean cord care procedures which are crucial in infection prevention. The umbilical cord should be cut with a clean (sterilized) blade and tied with clean (sterilized) materials, and no substances should be put on the cord stump (WHO, 1996). Sometimes blades of grass, bark fibers, reeds or fine roots are used to cut the cord. This is harmful because these materials often harbor tetanus spores from the soil and thus increase the risk of neonatal tetanus. Materials such as threads, strips of cloth and strings are used to tie the cord (Woodruff et al., 1984). The cord stump remains the major means of entry for infections after birth. Principles of clean cord stump care stipulate keeping the cord dry and clean and nothing is applied anything on it, neither at home or in the health facility. The stump will dry and mummify if exposed to air without any dressing, binding or bandages. It will remain clean if it is protected with clean clothes and is kept from urine

and soiling. No antiseptics are needed for cleaning. If soiled, the cord can be washed with clean water and dried with clean cotton or gauze.

Local practices of putting various substances on the cord stump whether in health facilities or homes should be carefully examined and discouraged if found harmful and substituted with acceptable ones (WHO, 2006). If the umbilical stump becomes red, drains pus with the redness extending to the skin around it, the baby stops suckling well, is sleepy, does not wake up or is having difficulty breathing, this may be a sign of serious infection. The mother or caretaker should seek help from a health facility. The baby must be referred immediately to the hospital for proper treatment (WHO, 2006). In the Sylhet District of Bangladesh, among the substances that were applied on the cord stump, after cord cutting; turmeric was the most common. Umbilical stump care revolved around bathing, skin massage with mustard oil and heat massage on the umbilical stump. Mothers were the principal provider for skin and cord care during the neonatal period. Unhygienic cord care practices are prevalent in the study area (Alamet *al.*, 2008).

Immunization

The WHO, (1996) stipulates that BCG should be given as soon after birth as possible in all populations at high risk of tuberculosis infection, and a single dose of OPV should be given at birth or two weeks after birth (this is recommended to increase early protection). Hepatitis B vaccine (HBV) should be integrated into national immunization programmes in all countries by 1997. Where perinatal infections are common it is important to administer the first dose as soon as possible after birth.

Early and Exclusive Breast-Feeding

According to the WHO, (2006) breast milk provides optimal nutrition and promotes the child's growth and development; it is associated with improved growth during the first months of life. By breast-feeding, a mother begins the immunization process at birth and protects her child against a variety of viral and bacterial pathogens before the acquisition of active immunity through vaccination. Breast milk has unique anti-infective properties. Frequent and exclusive breast-feeding can be an appropriate method of fertility regulation for many women, particularly when other family planning methods are not readily available or desired.

However, a study conducted by Yadav, (2007) on traditional practices in newborn care in Nepal shows that colostrum is regarded as dirty milk in some communities, and babies were fed with cow or goat milk immediately after birth for the popular belief that it will make the baby become more intelligent. Early contact (immediately after birth) between the mother and the baby, according to the WHO, (1999) has a beneficial effect on breast-feeding. Early suckling provides the baby with colostrum that offers protection from infection, gives important nutrients, and has a beneficial effect on maternal uterine contractions. Khadduri et al. (2008), state that most women breastfed their babies, but initiation within 1 hour of birth and colostrum feeding were not common. The baby's skin and gastrointestinal tract are colonized with the mother's microorganisms, against which she has antibodies in her breast milk. Important factors in establishing and maintaining breast-feeding after birth include: giving the first feed within one hour of birth, correct positioning that enables good attachment of the baby, frequent feeds, no prelacteal feeds or other supplements, and psychosocial support for breast-feeding mothers. Babies have a

wide range of behaviours following spontaneous delivery and are not all ready to feed at the same time.

A skilled person can help to facilitate the process by ensuring correct positioning and attachment. A healthy baby has no need for large volumes of fluid any earlier than they become available physiologically from the mother's breast. There is no evidence to support the practice of providing supplementary feeds of water, glucose or formula. Traditional prelacteal feeds should be strongly discouraged although harmless rituals may be allowed so long as they do not delay breast-feeding. Every birth attendant should also know the importance of unrestricted feeding and the ways to support breast-feeding mothers. Mothers should be instructed about the need for an adequate diet to sustain lactation. They should be helped and encouraged if they have difficulties breast-feeding (WHO, 1996). However, a study conducted in Haryana, India revealed that 75 percent of newborns were given prelacteal feeds of honey, tea and diluted milk, and babies are often not breastfed during the first 3 days. They are often given sweetened water; this presumes that colostrum was discarded (Bhandari et al., 2003). Rooming-in has many advantages over separating babies from mothers. In health facilities, its advantage, in addition to breastfeeding, is to prevent nosocomial infections.

Recognition and Management of Newborn Illness

According to the WHO (1996), many newborn problems can be prevented by the interventions described above. However, when a disease occurs, many deaths can be avoided if the signs are recognized early and the newborn managed effectively. Since most infants are either born at home or are discharged from the health facility early, families should be able to recognize signs of newborn illnesses and bring the newborn

infant to the attention of a health worker. The World Health Organization (1996) highly recommends early recognition of major newborn illnesses both at home and at the health center in order to refer the baby to hospital for management. The WHO explains further that many signs of the normal transition period mimic those of early disease.

Differentiation of signs of mild illness from normal transitional variation is difficult. Therefore disease is often in an advanced stage when the newborn is brought to the attention of the health workers. Danger signs in the newborn period are also non-specific; they can be a manifestation of almost any newborn disease.

The most common presentation of illness in an infant who has been doing well after birth is that he or she stops feeding well, is cold to the touch or - in rare cases – has fever. Breathing may be fast and difficult with grunting and intercostal retractions; the infant may be irritable but may become lethargic and not wake for feeds. The infant may vomit, have diarrhea and a distended abdomen. If pus is draining from red swollen eyes or from the umbilicus, classification of the problem is easier. Jaundice on the first day and convulsions are always a sign of a serious illness (WHO, 1996). A study conducted in a rural community in northern India which assessed household practices that can affect neonatal health among 200 caregivers. The study reported that more than half of the caregivers recognized fever, irritability, weakness, abdominal distention/vomiting, slow breathing and diarrhea as danger signs in neonates 30.38 percent of caregivers saw illness in neonates manifest in the form of continuous crying (Awasthi et al., 2008).

2.7 The Role of Community Health Nurses towards Increasing Mothers Awareness about Harmful Cultural Practice

The intervention strategies to minimize and eliminate harmful cultural practices when raising awareness is that the nurse should target everyone in the community especially young people, men, community leaders, religious leaders and the women who perform the harmful cultural practices (NAYHS and FMOH, 2007). In particular, the nurse need to work with both Islamic and Christian religious leaders as some of the justifications for practicing harmful traditional practices are incorrectly linked to religions. Most religious leaders teach their followers about the position of their religion with regard to such practices which will help in educating the community. It is crucial that the nurse should attempt to educate the traditional practitioners of harmful cultural practices about the dangers of such practices (NAYHS and FMOH, 2007). It is important to use educational activities to address the community's perceptions that there are disadvantages to practicing harmful cultural practices. This can often be done effectively by describing a case study of harmful cultural practices; the nurse should help by listening in a sympathetic and non-judgmental way. There may also be some medical assistance the nurse can offer, but there is the need to refer them to the next level of facilities for better psychosocial support and medical assistance.

Community education should be a focus of the National Rural Health Mission (NRHM) and Integrated Management of Neonatal and Childhood Illness (IMNCI) program being implemented in Karnataka. The added capacity of the new Accredited Social Health Activists (ASHAs) could enable more women to be reached. With careful tailoring of behaviour change messages to the local context, government outreach workers can

become effective brokers of positive change and significant improvements in home newborn care and neonatal mortality are possible (Kesterton and Cleland, 2009).

2.8 Empirical Studies

A study was conducted by Opara, Tamunopriye, Doris, Balafama, (2011) titled Newborn Cord Care Practices amongst Mothers in Yenagoa Local Government Area, Bayelsa State, Nigeria. The design used for this study was a cross-sectional study carried out amongst mothers attending three primary health care facilities with their infants in Yenagoa Local Government Area of Bayelsa State, Nigeria. Simple structured questionnaires were used to obtain information concerning the ages and sexes of babies, place of antenatal care and birth, treatments applied to the umbilical cord stump and the socioeconomic status of the parents. Data were analysed using SPSS version 16.0. The result revealed that 221 mothers participated in the study. The infants were aged 0 - 6 months with a male to female ratio of 1:1. 54 (24.4%) of mothers were of high social class. Cord care was done by grandmothers in 107 (48.4%) and mothers in 89 (40.3%) of babies. About 64 (29.0%) mothers had their babies cord cleaned with Methylated spirit alone while 138 (62.4%) cleaned with Methylated spirit and then applied other substances including antibiotic ointments and herbs. Maternal education, social class of parents and place of delivery were significantly associated with application of potentially harmful substances to the cord, ($p = 0.049, 0.010$ and 0.030 respectively). The commonest sources of information on cord care were nurses in 99 (44.8%) and grandmothers in 44 (19.9%). The study concluded that there is still a high rate of use of potentially harmful substances for cord

care and that All health workers should participate in educating mothers and grandmothers about optimal cord carePeace

A study was conducted by Gurong, (2008) to determine behavior's related to immediate care of newborn in Kailali district. Descriptive study was used for the study. The study was conducted in 6 purposely selected village Development committees (VDCs) Kailali, 17 Focus Group Discursion (FGDs) were conducted with 106 parents. The result indicated that most people are unaware of importance of immediate care of new born and many unsafe behavior do exist such as common use of untrained attendants, unsafe cord care, immediate bathing of baby. Most of the existing practices are based on deep-seated traditional beliefs

A retrospective study was carried out by Orin, Shrestha, Mesko, Shretha, Mamandhar, Standing and Manandhar, (2008). to determine home based new born care practice in rural Makwanpur district Nepal. The study involved 5411 married women aged 15 to 49 years who had given birth to a live baby in the past year. Results indicated that 4893(90%) women gave birth at home. Attendance at delivery by skilled health worker was low (34.6%), unlike attendance by traditional birth attendants (67.5%).It also showed that only 461(8%) of women had washed their hands, 3482(64%) newborn infants had been wrapped within half an hour of birth. Ninety two percent had been bathed within the first hour, 99% (5362) of babies were breast fed. The study concluded that health promotion interventions may likely to improve new born health, include increasing attendance at delivery by skilled service provider, improving information for families about basic prenatal care, promotion of clean delivery practices, early cord cutting and wrapping of the baby, and avoidance of early bath

A Descriptive study was conducted by Khadduari, (2008) on house hold maternal and newborn health knowledge and practices in Haripur district, Pakistan. Study was conducted using a semi-structural interviews and 34 Focus Group Discussions among men and women of reproductive age groups. Findings revealed that poor maternal diet and antenatal care seeking behavior, home delivery with unmarried traditional birth attendants was the norm. Respondents knew about benefits of clear delivery, knowledge and practice for maintaining the new born wrath were good. Delayed initiation of breast feeding, avoidance of colostrums and prelacteal feeding were almost universal, unhygienic cord care, including unclean cut and application of ghee on the cord-stomp was the norm after delivery. Mother's often maintained low fluid intake, but otherwise reported healthy nutritional practices. Although the finding illustrated some beneficial practices, many reported practices are harmful to the new born.

Darmstadt et al, (2007) conducted a study to provide information about home care practice for newborn in rural Egypt during the first week of life in 217 households in three rural areas. Many practices met common neonatal care standard's, particularly prompt initial breast feeding, feeding of colostrums and continued breastfeeding feeding and most bathing practices. Supplemental substances were given to 44% of newborns as pretacteal feeds and more than half during the first week nearby half(43%) of mothers reported that they did not wash their hands before neonatal care and only 7% washed hands after diaper changes. Thermal control was not practiced. The practice observed which one critical for new born survival could be improved with minor modifications.

A study was conducted to determine poor newborn care practice in Eastern Uganda by Waiswa, Peterson, Tom and Parito, (2010). All mothers with infants aged 1-4 months

(n=414) in a Demographic surveillance site were interviewed about three composite outcomes like good neonatal feeding, Good cord care, and optional thermal care were created by combining related individual practices from a list of 12 antenatal/essential newborn care practice there were low levels of coverage of newborn care practice among both the poorest and the least poor of new born 46% had a facility for delivery and only 38% were judged to have good cord care 42% optional thermal care and 57% were considered to have had adequate neonatal feeding. Mothers were putting power on the cord using a bottle to feed the baby and mixing /replacing breast milk with various substitutes. Most neonatal interventions are not reaching new born suggesting a 'policy – to practice gap'. Survival, newborn care should be integrated into the current maternal and child interventions, and health facility level as part of a universal coverage strategy.

A cross sectional survey was conducted by Bagui, Williams, Darmstadt, Kumar, Kiran, Panwar, Aharma, Ahmed, Sreevasta, Ahuja, Santosham and Black, (2007) to describe selected newborn care practice related to cord care, thermal care and breast feeding practice in rural Uttar Pradesh. The study included 13,167 women who had a live birth at home during the two year preceding data collection. The findings revealed that the use of antenatal care and skilled attendance at delivery were significantly associated with clean cord care and early breast feeding, but not with thermal care. Antenatal home visits by community-based worker were associated only with clean cord care. Women who received counseling from health workers were more likely to report the respective care practices. The association between newborn care practice and antenatal care counseling and skilled delivery attendance suggest that evidence based newborn care practice can be promoted through improved coverage with existing health services

Mrisho, Schellenbrg, mushi, Obrist, Mshinda, Tanner and Scheenbery, (2008) conducted a qualitative study in order to understand home based neonatal care practices in rural Tanzania. In-depth interviews, focus group discussion and case studies were used through a network of female community based informants in eight villages of Lindi rural and Tanadahimba districts. Data collection took place between March 2005 and April 2007. The result showed that lack of immediate appropriate care for both mother and baby vulnerable to witchcraft and great care is taken to shield both mother and baby from bad sprits until the cord stump falls off. Behavior change communication efforts are needed to improve early newborn care practices

Reshma and Sujatha, (2014) conducted a study on cultural practices and beliefs on newborn care among mothers in a selected hospital of Mangalore Taluk India. A descriptive research design was adopted for the study. Purposive sampling method was used to select 157 samples from a selected hospital. Demographic Performa and structured dichotomous questionnaire was used to collect the data from the subject. Data were collected from 157 samples which were analyzed using descriptive statistics. The results indicate that (149) 95% of the mothers practiced oil massage for the baby before bath. (83) 53% of the mothers provided home remedies for the baby. (87) 55% of the mothers were applying ashes, soot, powder, or dry cow dung, (115) 73% mothers exposed their babies to the sunlight when the baby's skin turns yellowish. (129) 82% of the mothers are applied 'Kajal' on baby's face to prevent bad eye. (92) 59% of the mothers are practicing a belief that “empty cradle should not be moved”. Interpretation and conclusion: Findings of the study revealed that there is a strong relationship between the demographic variables (type of family and religion) and cultural practices and beliefs on

newborn care among mothers. Periodical health education regarding do's and don'ts of newborn care should be conducted in postnatal ward, which will definitely minimize the unhealthy traditional.

Another study titled Survey of Home Delivery and Newborn Care Practices among women in a Suburban Area of Western Nigeria was carried out by Lamina, (2011). The objectives of this study were to describe the home delivery and newborn care practices and to assess the reasons for delivering at home. Study a cross-sectional survey design was carried out in the immunization clinics of Sagamu local government, Western part of Nigeria during January and February 2008. Two trained health workers administered a semi structured questionnaire to the mothers who had delivered at home. Main outcome measures planned or unplanned home delivery, reasons for delivering at home, the details of events that took place at home from the onset of labour pains till delivery and after birth till initiation of breast-feeding, attendance at delivery, cleanliness and hygiene practices during delivery, thermal control, and infant feeding. Results, A total of 300 mothers were interviewed. Planned home deliveries were 200 (66.7%) and 100 (33.3%) were unplanned. Only 13.4% of deliveries had a skilled birth attendant present, and 47 (15.7%) mothers gave birth alone. Only 51 (16.2%) women had used a clean home delivery surface. Majority (98.2%) of the newborns were given a bath soon after birth. Initiation rates of breast-feeding were 65.3% within one hour and 95.7% within 24 hours. Conclusion, high-risk home delivery and newborn care practices are common in semi urban population also. Community-based interventions are required to improve the number of families coming to health facilities and engaging a skilled attendant and hygiene during delivery.

Another study was carried out on Newborn care practices in rural Bangladesh, the objective of the study was to describe the pattern of neonatal care practices and their determinants in rural Bangladesh (Gary, 2006). The study was based on baseline data of a community-based intervention to assess impact of limited postnatal care services on maternal and neonatal health-seeking behavior. Data from 510 women, who had a live birth at home 1 year prior to survey, of six randomly selected unions of an Upazila (sub-district) were analyzed (Gary, 2006). Results: Majority of the respondents were at an age group of 20–34 years. Only 6% had delivery by skilled providers. Immediate drying and wrapping, and giving colostrums to newborns were almost universal. Unhealthy practices, like unclean cord care (42%), delayed initiation of breastfeeding (60%), use of prelacteals (36%), and early bathing (71%) were very common. Muslims were more likely to give early bath (adjusted odds ratio [OR]: 2.01; 95% confidence interval [CI]: 1.13–3.59; P=0.018) and delay in initiating breastfeeding (adjusted OR: 1.45; 95% CI: 1.18–1.78; P<0.001) to newborns. Practice of giving prelacteals was associated with teenage mothers (adjusted OR: 2.26; 95% CI: 1.19–4.28; P=0.013) and women’s lack of education (adjusted OR: 2.64; 95% CI: 1.46–4.77; P=0.001) (Gary, 2006) the study Concluded that unhealthy neonatal care practices are widespread in rural Bangladesh. Continued education to the community and home delivery attendants on essential newborn care could benefit newborn survival in Bangladesh (Gary, 2006).

A cross sectional study on factors associated with harmful traditional practices among children less than 5 years in Axum town, north Ethiopia Gebrekirstos *et al.*,(2013). The objective of this study was to assess factors associated with harmful traditional practices among children less than 5 years of age in Axum town, North Ethiopia. The method used

was community based cross sectional study was conducted in 752 participants who were selected using multi stage sampling; Simple random sampling method was used to select ketenas from all kebelles of Axum town. After proportional allocation of sample size, systematic random sampling method was used to get the study participants. Data was collected using interviewer administered Tigrigna version questionnaire, it was entered and analyzed using SPSS version 16. Descriptive statistics was calculated and logistic regressions were used to analyze the data. The results indicated that out of the total sample size 50.7% children were females, the mean age of children was 26.28 months and majority of mothers had no formal education. About 87.8% mothers had performed at least one traditional practice to their children; uvula cutting was practiced on 86.9% children followed by milk teeth extraction 12.5% and eye borrows incision 2.4% children. Fear of swelling, pus and rapture of the uvula was the main reason to perform uvula cutting. The study concluded that the factors associated with harmful traditional practices were educational status, occupation, religion of mothers and harmful traditional practices performed on the mothers (Gebrekirstos *et al.*, 2013).

A study on Umbilical Cord Care Practices in Konduga Local Government Area of Borno State North - Eastern Nigeria was conducted by Ambe, Bello, Yahaya, Omotara, (2008). The objective of this study was to identify the practices of cord care in Konduga Local Government Area of Borno State, North-Eastern Nigeria. The study was conducted in 5 districts (Konduga, Auno, Dalwa, Malari and Kawuri) of Konduga Local Government Area (LGA), in Borno State, North Eastern Nigeria. The survey, which was cross-sectional, was conducted over an eight week period, in the year 2005. Systematic random sampling method was employed to select respondents in the study. Each household was

considered a sampling unit and the tenth household was selected from every 40 household. Data were collected based on a proforma questionnaire. Four hundred questionnaires were administered to mothers. Information obtained included bio-data of the parents, attendance of antenatal care during last pregnancy and number of Tetanus toxoid given, place of delivery and information's about cord care. Medical problems of the child in the first few days of life; history of stiffness and or death among previous children during the period of cord care, and knowledge of any child who had similar problem in the community were also sought and documented (Ambe et al., 2008). Results revealed 183 (45.8%) were full time house wives, 89 (22.3%) were small scale farmers, 74 (18.5%) were traditional/skilled handworkers and 54 (13.5%) were civil servants/students. Majority of the mothers, 256 (64%) did not have any formal education, 69 (17.3%) had primary education, while 75 (18.7%) had post primary education. The age and parity of the mothers are within majority among the age group of >35 (102) years of age, followed by those of age 20 – 24(93) (Ambe et al., 2008). The result of this study also indicated that majority of the fathers do not have any formal education, this also may contribute to the poor understanding of the mothers/care giver about the harmful practices with use of these substances in cord care. Also majority of mothers despite the ANC attendance delivered at home which may be a reflection of the educational background of their husbands.

From the above study, only 28 (11.5%) received up to 4 doses of TT, while 202(83.1%) received between 1 – 3 doses. Thus the mothers may not have been immunized well enough against tetanus. In tying the cord, majority used thread and strings, these are materials not sterilized. They may contribute to the infection of the cord. Not tying the

cord may also lead to bleeding, which may cause mild to moderate anaemia in the newborns affecting their growth and development, and if it became severe, may lead to death. It is a practice that needs to be discouraged (Ambe et al, 2008). From this study, 90.8% of the mothers did not have any problem during the period of cord care; however, 19.2% did have problems, ranging from fever to skin rashes. The large majority of mothers / care givers, who indicated that they did not have any problem, may have said so for the fear of being seen as irresponsible. Thus, there is the need to look into this aspect, perhaps by having a focused group discussion or a different questionnaire to address this aspect (Ambe *et al.*, 2008).

Various materials have been used for tying the cord, which includes strings, threads and strips of cloth. In this study the use of thread (73.3%), strings (8.5%) and cord clamp (4%) is reported. A few (7%) left the cord untied; this practice has also been reported by Garner, The practice of not tying the cord increases the risk of bleeding from the umbilical stump with attendant morbidity and mortality. In many cultures, some substances are applied to the umbilical stump. Some of these include ash, oil, butter, spice paste, herbs and mud. In this study, hot fermentation was used in 126 (31.5%), rag and lantern 78(19.5%), Vaseline 38 (9.5%), ash/charcoal 37 (9.3%), methylated spirit or disinfectant 34 (8.5%), groundnut/palm/mangrove oil 33 (8.3%), others were, use of powder (6.5%), red sand (3.5%), hot /saline water (2.0%), salt or just left alone (1.5%). Most of these practices are harmful because these substances are often contaminated with bacteria and spores, thus increasing the risk of infections (Ambe *et al.*, 2008).

A study conducted in low socioeconomic settlements of Karachi, Pakistan, by Fikree et al., (2005). The findings revealed that newborns were bathed immediately after delivery

as the vernix was considered “dirty looking” and it was felt it should be removed. Daily massage of the newborn with mustard oil and risky feeding practices such as giving prelacteals, supplementary feeds, delaying first feed were common. Apart from breast milk which was the preferred feed during neonatal period, other feeds like honey, ghutti and water were also given in order to reduce colic or act as laxative, these were perceived health benefits mentioned by mothers as well as TBAs (Fikree *et al.*, 2005).

2.9 Theoretical Frame Work

Health Belief Model (HBM)

Health Belief Model (HBM) according to Turner, Hunt, DiBrezzo and Jones, (2004) is one of the first theories of health behavior. It was developed in the 1950s by a group of U.S. Public Health Service social psychologists who wanted to explain why so few people were participating in programs to prevent and detect disease. HBM is a good model for addressing problem behaviors that evoke health concerns (e.g. high-risk sexual behavior and the possibility of contracting HIV)

HBM is also known as Lewin's theory. It makes effort to identify and critically evaluate the factors responsible for human behavior as it relates to individual health. Lewin's theory focuses on the prevention of diseases and is strongly oriented towards the individual perceptions of the world and how such perceptions motivate behaviour. (Gbefwi, 2004).

2.9.1 Core Assumptions and Statements

The HBM is based on the understanding that a person will take a health-related action if that person:

1. feels that a negative health condition can be avoided,
2. has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition
3. believes that he/she can successfully take a recommended health action

2.9.2 Theoretical Constructs

Four perceptions serve as the main constructs of the model:

1. perceived seriousness
2. perceived susceptibility
3. perceived benefits
4. perceived barriers.

Each of these perceptions, individually or in combination, can be used to explain health behavior. More recently, other constructs have been added to the HBM; thus, the model has been expanded to include:

5. Cues to action
6. Motivating factors, and
7. Self-efficacy

More details about the construct of the theory are:

1. Perceived Seriousness

The construct of perceived seriousness speaks to an individual's belief about the seriousness or severity of a disease. While the perception of seriousness is often based on medical information or knowledge, it may also come from beliefs a person has about the difficulties a disease would create or the effects it would have on his or her life in general

2. Perceived Susceptibility

Personal risk or susceptibility is one of the more powerful perceptions in prompting people to adopt healthier behaviors. The greater the perceived risk, the greater the likelihood of engaging in behaviorsto decrease the risk. Perceived susceptibility for example motivates people to be vaccinated for influenza. Perception of susceptibility

explains behavior in some situations, but not all. When the perception of susceptibility is combined with seriousness, it results in perceived threat. If the perception of threat is to a serious disease for which there is a real risk, behavior often changes.

3. Perceived Benefits

The construct of perceived benefits is a person's opinion of the value or usefulness of a new behavior in decreasing the risk of developing a disease. People tend to adopt healthier behaviors when they believe the new behavior will decrease their chances of developing a disease.

4. Perceived Barriers

Since change is not something that comes easily to most people, the last construct of the HBM addresses the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behavior. Of all the constructs, perceived barriers are the most significant in determining behavior change (Turner *et al.*, 2004). In order for a new behavior to be adopted, a person needs to believe the benefits of the new behavior outweigh the consequences of continuing the old behavior (Centers for Disease Control and Prevention, 2004). This enables barriers to be overcome and the new behavior to be adopted.

5. Modifying Variables

The four major constructs of perception are modified by other variables, such as culture, education level, past experiences, skill, and motivation, to name a few. These are individual characteristics that influence personal perceptions (Turner *et al.*, 2004).

6. Cues to Action

In addition to the four beliefs or perceptions and modifying variables, the HBM suggests that behavior is also influenced by cues to action. Cues to action are events, people, or things that move people to change their behavior. Examples include illness of a family member, media reports, mass media campaigns, advice from others, reminder postcards from a health care provider, or health warning labels on a product

7. Self-Efficacy - In 1988, self-efficacy was added to the original four beliefs of the HBM.

Self-efficacy is the belief in one's own ability to do something. People generally do not try to do something new unless they think they can do it. If someone believes a new behavior is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried.

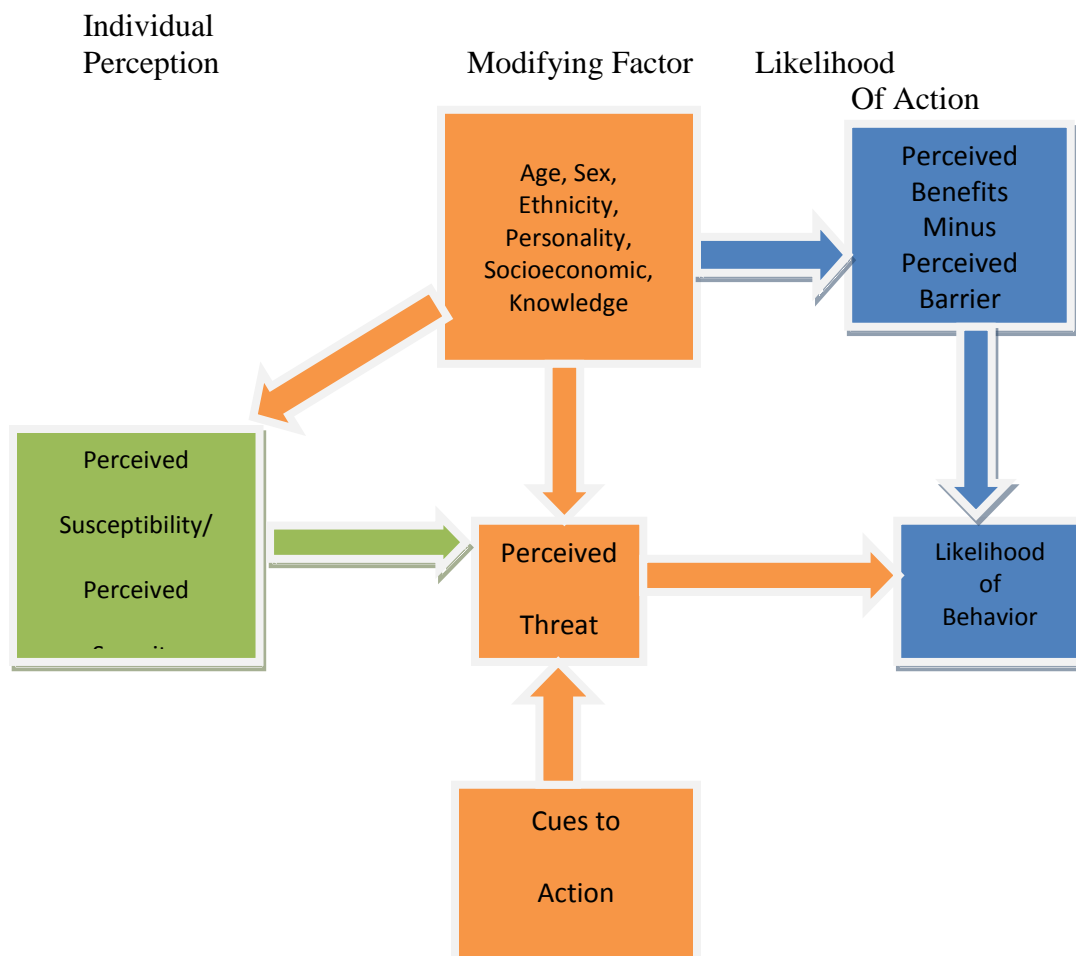


Fig 2.1 Health Belief Model (Turner, Hunt, DiBrezzo and Jones, 2004).

2.9.3 Application of Health Belief Model to the Study

The rationale for the selection of this model is based on how mothers perceive culture and their beliefs concerning neonatal health care in Igabi LGA of Kaduna State.

Health Belief Model used by the researcher for this study as follows:

1. Perceived seriousness/ suseptibility (Personal Risk)

This is when the mothers belief their babies are not at risk or have low risk of susceptibility, unhealthy behaviour may result such as traditional uvulectomy, FGM, force feeding, tribal mark, administration of concoction to the neonates etc. which may be

dangerous to the wellbeing of the neonate. But if the mothers perceived the practice as harmful, that they may expose their babies to infection, they will be more likely to do something to prevent it from happening. It is the perception of threat of recurrence that increases the likelihood of behavior change in the mothers on their neonatal health.

2. Percieved Benefits

Perceived benefits are mother's opinion of the value or usefulness of a new behavior in decreasing the risk of developing complications. Mothers tend to adopt healthier behaviors when they believe the new behavior will decrease their chances of developing a complication. For example, after the use of chlorohexane on babies umbilical cord, the mother then weigh the benefit comparing it with her previous experience where she uses cow-dung to hasten the fall of the cord. The mother will tend to adapt the healthier behavoiur.

3. Perceived Barrier

Mother's opinion as to what will stop her from adopting the new behavior. In order for a new behavior to be adopted, mothers needs to believe the benefits of the new behavior outweigh the consequences of continuing the old behavior. This enables barriers to be overcome and the new behavior to be adopted. The barriers could be low socioeconomic status, lack of awareness about the effect of HCP, belief, ignorance, fear, past experience, fear of hospitals, decision maker in the family etc. This will definitely prevent the mothers from adapting to healthy neonatal care.

4. Mordifying Variable

These are mother's characteristics that influence their perception on neonatal health. In this study, the characteristics include nursing mothers or mothers who had nurse a child not more than one year ago and are within their reproductive age group. The mothers are

mainly Muslims and Hausa/Fulani by tribe and have low socio- economic income. Their past experience also can modify their neonatal health seeking behaviour.

5. Cues to Action

In this study, cues to action could be mass media discouraging harmful cultural practices on neonatal health, health talks in clinics, market place, out reaches in communities and hard to reach areas encouraging women to attend antenatal, intra-natal as well as post-natal care in the health facilities and the use of reminder postcards from a health care provider.

6. **Self-Efficacy** -This is the mothers personal belief in ones own ability to do positive behavior change. This usually comes out after the mother has been convinced about the benefit of a practice comparing it with the previous practice.

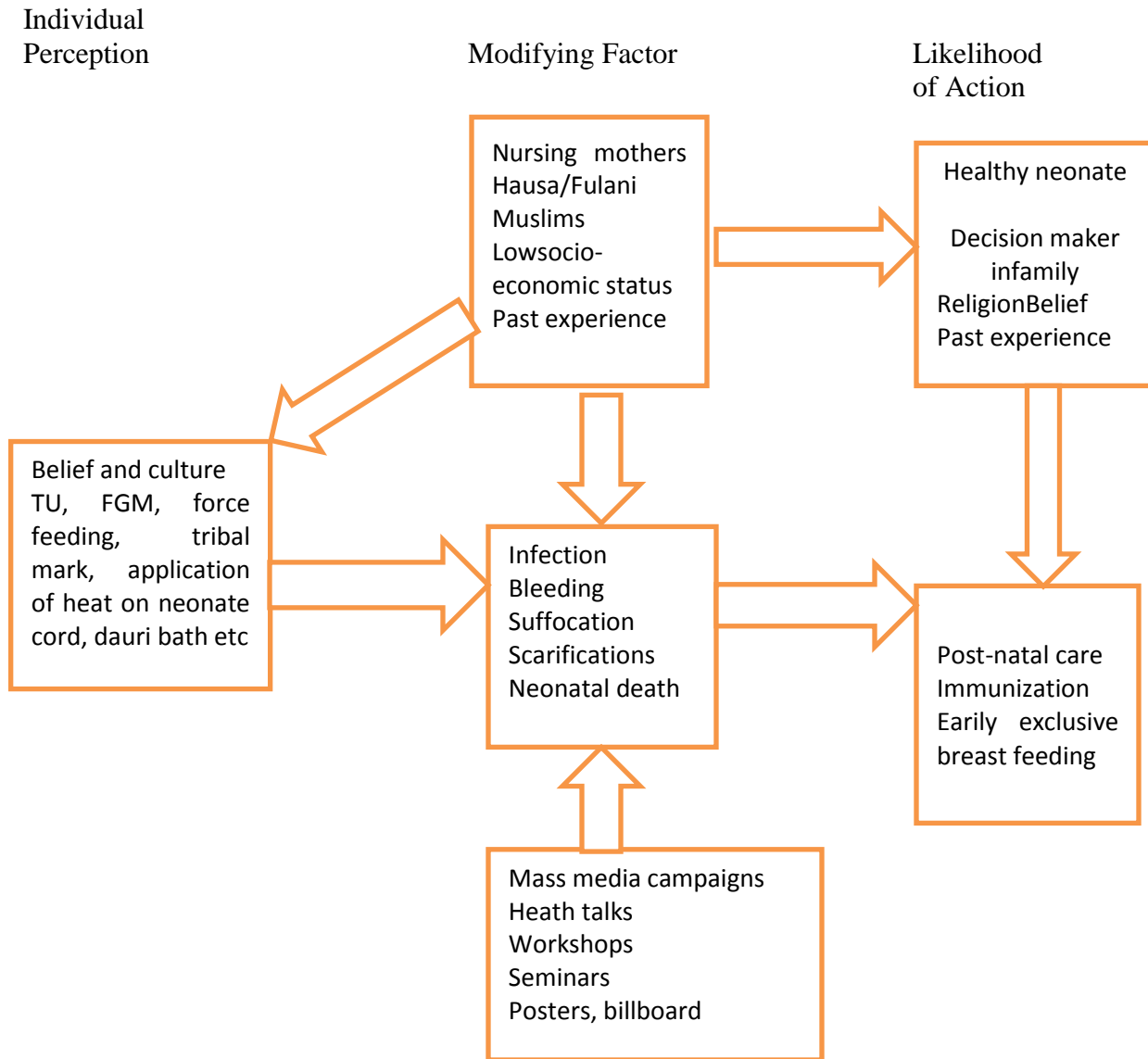


Fig 2.2 (Application of Health Belief Model of Cultural Beliefs and Practices of Mothers towards Neonatal Health. By self.

2.10 Summary

This chapter covered the available review of related literatures. The review examined the assessment of Cultural Beliefs and Practices of Mothers towards Neonatal health in Kaduna State. Literatures in the areas of cultural practices, beliefs and neonatal care in

Africa and Nigeria were also reviewed based on the stated objectives as follows, Culture, Beliefs and Practices of Mothers on Neonatal Health, Reasons for performing Cultural Practice on Neonate, Common Harmful Cultural Practices on Neonate, Awareness of mothers about the effect of harmful cultural practices on neonatal health, National intervention to reduce neonatal/infant morbidity and mortality rate, National policy on neonatal health, and The role of nurses towards increasing mothers awareness about harmful neonate health practice and health belief model.

CHAPTER THREE

MATERIALS AND METHODS

3.1 Introduction

This chapter presents the research method, research design, area of study, the study population, sample size, sampling technique, instruments for data collection, validation of instrument, ethical consideration, method of data collection, method of data analysis.

3.2 Design

A cross sectional descriptive study was used in this study. It examines the relationship between diseases or health related state and other variables as they exist in a defined population at a single point in time or over a short period of time. This method was used because it was non experimental research and the information required for the research was already with the respondents.

3.3 Area of Study

The area of study was Igabi LGA of Kaduna State. It was created in 1989 out of the Zaria local government with twelve political wards which include; Igabi, Rigachikun, Rigasa, Farakwai, Zangon Aya, Afaka, Kerawa, Fan shanu, Kwarau, Sabon Birni, Kwaraje, Turunku, Birnin Yero. The headquarters of the local government is located in Turunku. The local government is dominated by traders and farmers who produce food crops on commercial level. Major crops produced in the local government include; yams, maize, guinea corn, beans, and sugarcane. Igabi local government is composed of different kind of tribes. However the main spoken language is Hausa, Fulani, Gwari and a few others at

a smaller group. Islam and Christianity are the main religion being practiced by the people in the local government. Igabi local government has social amenities such as pipe borne water supply, road network with good drainage systems and public health facilities. There are a total of 71 primary health centers and secondary Health Facilities in Igabi local government having a total population of 116126 according to National Population census 2006 projected in 2016.

3.4 Target Population

The target populations of the study were nursing mothers who were currently breast feeding their babies that are 12 months or less than 12 months old and those that weaned their baby within the year of study. The mothers had to be resident of the ward. The total population was gotten from the immunization coverage of children under 1 year in Igabi LGA. The population was 14061 (Igabi Local Government Seceteraite National Population census 2006 projected in 2016)

3.5 Sample Size

A total of 400 breast feeding mothers were recruited in this study. The sample size was determined by using (Yamane, 1967). He provided a formula that reads thus;

$$n = \frac{N}{1 + N(e)^2}$$

Where n = sample size

N = target population (14061)

e = level of precision as 5% = 0.05

Therefore, $n = \frac{N}{1 + N(e)^2}$

$$n=14061/1+14061 (0.05)^2$$

$$n =14061 /1+14061 (0.0025)$$

$$n = 14061/14062(0.0025)$$

$$n = 14061/35.155$$

$$n = 399.9$$

$$n = 400$$

Inclusion Criteria includes the following:

Mothers had to be ordinarily resident in the wards and were currently breast feeding their babies from birth – 12months old or who had nursed a baby within 1 year, willing to participate in the study , able to give informed consent and attending the health facilities during the study.

Exclusion Criteria

Mothers who were unwilling to participate in the study, mothers whose babies were more than 1year old. Health or mental condition rendering it impossible for the mothers to obtain informed consent or to fill the questionnaire. Mothers who were too sick to be given consent or to be interviewed.

3.6 Sampling Technique

Multistage sampling technique was used to collect the determined sample. This type of sampling is mainly used when the population is too large and scattered. For it to be practical, a list of the entire population was determined and a series of stages were used for the selection. Table (3.1) shows more details.

Stage 1 - Identification of the wards in Igabi Local Government Areas.

Igabi Local Government Area consisted of 12 political wards. The twelve political wards include; Igabi, Rigachikun, Rigasa, Farakwai, Zangon Aya, Afaka, Kerawa, Fan shanu, Kwarau, Sabon Birni, Kwaraje, Turunku, Birnin Yero.

Stage 2 –Clustering of the 12 wards into 2 complexes

- 1) Complex A..... 6 wards
- 2) Complex B..... 6 wards

The two complexes are made up of six wards each.

Stage 3 – selection of the 3 wards per complex

Using a simple random sampling technique in which paper basket method was used three (3) wards each were selected from the two complexes. The selected wards from the complexes are:

- 1) Complex A
 - (a) Rigasa ward..... 7835 Immunization coverage of children under 1year
 - (b) Afaka ward.....1688 “ “ “
 - (c) Rigachuku ward.....1340 ” “ “
 - 2) Complex B
 - (a) Zangon Aya ward869 ” “ “
 - (b) Igabi ward1079 ” “ “
 - (c) Birnin Yero ward.....1250 ” “ “
- Total = 14,061

Stage 4- proportionate allocation per ward

The stage 4 involved proportionate allocation using

$$X = A/B \times n$$

Where X - Sample size allocated to each ward

n - Sample size (400)

A - Total immunization coverage of less than 1 year in a selected ward

B – Total immunization coverage of less than 1 year in the 6 selected wards (14016)

Therefore, sample size allocated to each ward is – 400

1.

$$\begin{aligned} \text{Rigasa ward} &= \frac{\text{Total immunization coverage of under 1year in Rigasa} \times \text{Sample size}}{\text{Total immunization coverage of under 1year in the 6 selected wards}} \\ &= \frac{7835 \times 400}{14061} \\ &= 223 \end{aligned}$$

2.

$$\begin{aligned} \text{Afaka ward} &= \frac{\text{Total immunization coverage of under 1year in Afaka ward} \times \text{Sample size}}{\text{Total immunization coverage of under 1year in the 6 selected wards}} \\ &= \frac{1688 \times 400}{14061} \\ &= 48 \end{aligned}$$

3.

$$\begin{aligned} \text{Rigachuku ward} &= \frac{\text{Total immunization coverage of under 1year in Rigachuku ward} \times \text{Sample size}}{\text{Total immunization coverage of under 1year in the 6 selected wards}} \\ &= \frac{1340 \times 400}{14061} \\ &= 38 \end{aligned}$$

4.

$$\begin{aligned} \text{Zango Aya ward} &= \frac{\text{Total immunization coverage of under 1year in Zango Aya ward} \times \text{Sample size}}{\text{Total immunization coverage of under 1year in six selected wards}} \\ &= \frac{869 \times 400}{14061} \end{aligned}$$

$$= 25$$

5. Igabi ward = $\frac{\text{Total immunization coverage of under 1year in Igabi ward} \times \text{Sample size}}{\text{Total immunization coverage of under 1year in the 6 selected wards}}$

$$\frac{1079 \times 400}{14061}$$

$$= 31$$

6. Birnin Yero ward = $\frac{\text{Total immunization coverage of under 1year in Birnin Yero ward} \times \text{Sample size}}{\text{Total immunization coverage of under 1year in the 6 selected wards}}$

$$\frac{1250 \times 400}{14061}$$

$$= 35$$

Stage 5 - Selection of respondents (nursing mothers) per PHC in each ward, there are a total of 42 PHC in the 6 selected wards as indicated in the appendix. All the PHC were used for the study.

Stage 6-Convenience sampling was used for the selection of nursing mothers. A convenience sampling is a non-probability sampling technique where subjects are selected because of their convenience accessibility and proximity to the researcher. The questionnaire were self and interviewer administered by the researcher and the research assistants.

Table 3.1 Summary of the Multistage Sampling Procedure

Stage	Sampling Methods	Description
1	Identification of the 12 existing wards in Igabi Local Government Area of Kaduna State	Igabi, Rigachikun, Rigasa, Farakwai, Zangon Aya, Afaka, Kerawa, Fan shanu, Kwarau, Sabon Birni, Kwaraje, Turunku, Birnin Yero
2	Clustering of the 12wards into 2 complexes based on geographical region	Complex A; Sabon Birni, Rigachikun, Rigasa, Afaka, Fan shanu, Kerawa Complex B; Kwarau, Birnin Yero, Kwaraje, Farakwai, Igabi, ZangonAya,
3	Selection of 3 wards per complex (Simple random Sampling using paper basket method)	Complex A ; Rigasa ward (7835), Afaka ward (1688) and Rigachukuward (1340) Complex B ; Zangon Aya ward (869), Igabi ward (1079) and Birnin Yero ward (1250)
4	proportionate allocation of ward using formula $X = A/B \times n$ Where X - Sample size allocated to each ward n - Sample size 400 A - Total immunization coverage of under 1year in a selected ward B - Total immunization coverage of under 1yearin six selected wards (14016)	Rigasa ward – 223 Rigachuku ward – 38 Afaka ward – 48 Zangon Aya ward – 25 Igabi ward – 31 Birnin Yero ward – 35 Total = 400
5	Selection of respondents (nursing mothers) per PHC in each ward, there are a total of 42 PHC in the 6 selected wards.	All the PHC were used for the study. The number of sample size in each PHC was determined by dividing the sample size according to the number of PHC in each ward
6	Convenience samplingwas used for the selection of nursing mothers in all the PHC.	

Table 3.2 Summary of Selected Wards, Target Population and Sample size

Selected Wards	Target Population	Sample Size
Rigasa	7835	223
Birnin Yero	1250	35
Rigachuku	1340	38
Igabi	1079	31
Zangon Aya	869	25
Afaka	1688	48
TOTAL	14061	400

3.7 Tools and Instrument for data collection

Based on the review of previous studies and related literatures, the main tool used for the data collection was semi structured interview questionnaire. It was adapted from Reshma & Sujatha, (2014) and modified by the researcher to cover the objectives and research questions of the study. It comprises of five sections as the following;

Section A:It is mainly to collect data about the Socio-demographic characteristics of mothers and sought personal data on age, occupation, religion, educational level, tribe, and parity. It composed of (14) questions

Section B:It is mainly to collect data on the opinion about cultural beliefs and practices of motherstowards neonatal health. It composed of (31) questions.

Section C: It is mainly to collect data about reasons for performing cultural practices of mothers on neonate. It composed of (7) questions

Section D: Common cultural practices of mothers on neonate in Igabi LGA of Kaduna State. It composed of (10) options.

Section E - Mothers awareness about the effect of harmful cultural practices towards neonatal health. It composed of (7) questions.

The response modes of the questionnaire items were in form of multiple choice options or close ended and tick. In case the respondents could not read and write or understand English, each statement of the questionnaire was translated to the language understood by the research assistant and recorded in English.

3.8 Validation

The drafted questionnaire together with the objectives of the study were submitted to five professional experts in Community Medicine Department and Department of Nursing Science Ahmadu Bello University Zaria Nigeria for content and face validation. The experts looked at the instruments and decided that the questions can elicit the information required to answer the research questions and will satisfy the objectives of the study. Suggested advices were incorporated into the final draft of the questionnaire. Final draft which was approved by the experts.

3.9 Ethical Consideration

An introductory letter was obtained from department of Nursing Science ABU Zaria together with four copies of research proposal which contains the title of the study, statement of problem, objectives, research questions, review of related literature, and methodology which was submitted to Kaduna State Ministry of Health in other to collect an ethical clearance. Ethical clearance letter from the Ministry of Health Kaduna was obtained. Permission was obtained from the in-charges of various health facilities before

administering the questionnaire to the mothers. The respondents were briefed on the purpose of study and confidentiality was assured.

3.10 Procedure for Data Collection

1. An introductory letter was obtained from the Department of Nursing Science A.B.U, Zaria.
2. Administrative clearance was obtained from the Ministry of Health Kaduna before conducting the research.
3. Permission was obtained from the in-charge of various health facilities before administering questionnaire to the respondents.
4. A verbal informed consent detailing the study purpose, benefits and absence of possible risks of the study to the respondents was provided to them. The respondents were also briefed on how to fill the questionnaire. Strict confidentiality was assumed and adhered to in respect of those whom the questionnaire will be administered to, informed consent was obtained from the respondents before the administration of the questionnaire.
 - The aims and objectives of the study were explained to them.
 - The respondents were assured of confidentiality of their identities and names including information which were collected from them

Six co-researchers, who are able to read, write, speak English and Hausa were recruited and trained as research assistants. The training covered a period of three days. The researcher coordinated the whole exercise. In case where the respondents could not read and write or understand English. Each statement of questionnaire was translated to Hausa by the research assistant and then recorded in English. Copies of the questionnaire

were collected upon completion by the research assistants and then handed over to the researcher. The collection of data started from October 2016 to December 2016.

3.11 Procedure for Data Analysis

The data collected from the participants were coded and entered into the Statistical Package for the Social Sciences (SPSS) version 20.0 for analysis. Appropriate descriptive and inferential statistical techniques (chi-square) was used for the analysis. Frequency tables and percentages were applied in the computation of the respondent demographic characteristics and presentation of variables relating to cultural beliefs and practices of mothers on neonatal health.

3.12 Limitation

The questionnaire were not completely filled this brings about (n) with different values.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the data analysis of the study which aimed at assessing cultural beliefs and practices of mothers towards neonatal health in Igabi Local Government of Kaduna State. A total of 400 questionnaires were distributed which 388 were returned. The response rate is 95%. The results of which was presented in two sections: A-descriptive statistics and B-inferential statistics.

A - Descriptive statistics used on the following;

1. Sociodemographic characteristics of mothers and obstetric history. Table (4.1 – 4.2)
2. Mothers opinion on cultural practices on neonatal health. Table (4.3 – 4.10)
3. Mothers reasons for performing cultural practices on neonatal health. Table (4.11)
4. Common harmful cultural practices on neonate among mothers. Table (4.12)
5. Mothers awareness about the effect of harmful practices on neonate. Table (4.13)

B - Inferential statistics used on the following;

- 6 Relationship between sociodemographic characteristics and cultural beliefs of mothers on neonatal health. Table (4.14)
- 7 Relationship between sociodemographic characteristics and cultural practices of mothers on neonatal health Table (4.15)

Section 1: Socio-demographic characteristics of mothers

Table (4.1) Socio-demographic Characteristics of mothers

Variables	Frequency	Percentage
Mothers age (n=388)		
≤ 20 years	25	6.8
21 – 30 years	195	50.3
31 – 40 years	138	35.6
41 – 50 years	29	7.5
Religious status (n=388)		
Muslim	369	95.1
Christian	18	4.6
Others	1	0.3
Marital status (n=387)		
Married	373	96.3
Separated	8	2.0
Widow	5	1.2
Occupation of mothers (n=386)		
Employed	129	33.4
Unemployed	257	66.5
Level of education of mother (n=386)		
Primary	151	39.1
Secondary	163	42.2
Tertiary	11	2.8
Others	61	15.8
Family income (n=105)		
≤ 9,000	26	24.8
10 – 31,000	67	63.8
≥ 32	2	1.9
No response	1	0.9
Ethnic group of mothers (n=384)		
Hausa/Fulani	321	83.6
Igbo	2	0.5
Yoruba	13	3.3
Nupe	32	8.3
Gbaji	16	4.1

*The total number of the mothers differ in each variables based on the complete and correct response of the mothers

Table (4.1) Revealed that most of the mother's age ranges from 21 – 40years 333 (85.9%)and all most all were Muslims 369 (95.1%) and were unemployed 257 (66.5%).

The majority of mothers attended both primary and secondary education 314 (81.3%).

The Table also showed that more than half of the mother's family income per month ranges from 10 - 31,000 naira 67(63.8%). Most of the mothers ethnic group was Hausa/Fulani 321 (83.6%).

Table (4.2): Mothers previous and current obstetric history

Variables	Frequency	Percentage
Parity (n=388)		
1 – 4	210	54
≥ 5	170	44
No. of children alive (n=386)		
1 – 4	210	54
≥ 5	178	46
Place of delivery (n=387)		
Home	222	57
Hospital	163	42
Other	2	1
Who conducted the deliveries (n=388)		
Skilled health provider (Nurses, Midwives, Dr, Chew	118	30
Unskilled health provider (TBA, Auxiliary Nurse)	270	70
Did you plan to deliver at home? (n=386)		
Yes	183	47
No	203	53
Reasons why you prefer to deliver at home (n=183)		
Past experience	75	41
Economic issue	47	26
Emergency condition	47	26
Attitude secured at home	12	7
Feel secured at home	2	1

*The total number of the mothers differ in each variables based on the complet and correct response of the mothers

Table (4.2) showed parity of mothers where most of the mothers 210 (54%) had 1 – 4 pregnancies and also 210 (54%) had 1 – 4 children alive. The Table also revealed that more than half of the mothers 222 (57%) delivered their babies at home. Majority of the deliveries 270 (70%) were conducted by unskilled health providers. The Table also indicated that more than half of the mothers 203 (53%) do not plan to deliver their babies at home and that for those that plan to deliver at home showed that their reason was due to their past experience 75 (41%).

Section 2: Mothers opinion on cultural practices on neonate

Table (4.3):Mothers opinion on cultural practices on neonate

Variables	Frequency	Percentage
Do you accept cultural practice (n=385)		
Yes	314	82
No	71	18
Reasons for acceptance (n=314)		
Beneficial practice	193	61
Based on culture	116	37
No reason	5	2
Reasons for rejection (n=71)		
It is harmful practice	24	34
Personal perception	17	24
Religious beliefs	2	3
No reason	1	1
Exposure	27	38
Do you perform cultural practice on neonate (n=388)		
Yes	304	78
No	84	22

*The total number of the mothers differ in each variables based on the complet and correct response of the mothers

Table (4.3) revealed that most of the mothers 314 (82%) accept cultural practice on their neonates, because it issaid to be a beneficial practice 193 (61%). Others accepted it based on culture 116 (37%). The Table also showed that those who do not belief in the practice indicated that it is a harmful practice 24 (33.8%). The result from thisTable also revealed that majority of the mothers304 (78%) performed cultural practices on their neonate.

Table (4.4): Mothers opinion on cultural practices regarding neonatal bath

Variables	Yes		No		No response	
	Freq	%	Freq	%	Freq	%
Messaging the baby with oil before bath (n=379)	116	31	230	61	33	9
Giving bath to baby with milk (n=379)	15	4	272	72	92	24
Bathing the baby 3 times a day (n=374)	76	20	261	70	37	10
Using traditional soaps in bathing the baby (n=378)	318	85	46	12	14	4
Throwing the baby up after bath (n=372)	252	68	97	26	23	6
Applying concoction on the baby's body before bath (n=374)	101	27	235	63	38	10

*The total number of the mothers differ in each variables based on the complete and correct response of the mothers

Table (4.4) showed that more than half of the mothers 230 (61%) do not massage their baby with oil before bath, most of them 272 (72%) do not use milk in bathing their baby and do not bath their babies 261 (70%) three times in a day. The Table also showed that quite a number of the mothers 318 (85%) use traditional soaps in bathing their babies and also throw their baby up after birth 252 (68%). The Table also indicated that more than half of the mothers 235 (63%) do not apply concoction on the baby's body before bath.

Table (4.5): Mothers opinion on cultural practices regarding neonatal feeding

Variables	Yes		No		No response	
	Freq	%	Freq	%	Freq	%
Fed baby immediately after delivery with breast milk (n=379)	328	87	48	13	3	0
Fed on the first day with glucose (n=378)	201	53	159	42	18	5
The baby was fed on the first day with honey (n=379)	289	76	79	21	11	3
Feeding the baby with formula milk (n=371)	71	19	271	73	29	8
Giving hot water to evacuate the stool (n=356)	203	57	131	37	22	6
Giving home remedies for digestion (n=330)	220	67	110	33	0	0

*The total number of the mothers differ in each variables based on the complete and correct response of the mothers

The Table (4.5) showed that majority of the mothers 328 (87%) fed their babies immediately after delivery with breast milk. Fifty three percent fed their babies on the first day with glucose and 289 (76%) fed their babies on the first day with honey. The Table also revealed that most of the mothers 271 (73%) do not feed their babies with formula milk, more than half of them 203 (57%) gave their babies hot water to evacuate their stool and 220 (67%) administered home remedies to their babies for digestion.

Table (4.6): Mothers opinion on cultural practices regarding umbilical cord care

Variables	Yes		No		No response	
	Freq	%	Freq	%	Freq	%
Old blade should be used to cut the baby's cord (n=376)	42	11	280	74	54	14
Surgical blade should be used to cut the baby's cord (n=368)	280	76	42	11	54	15
What do you apply on the baby's cord to hasten it fall (n=376)						
- Home remedies	173	46	203	54	0	0
- Application of heat	150	40	226	60	0	0
- Spirit/Chlohezidine	53	14	323	86	0	0

*The total number of the mothers differ in each variables based on the complet and correct response of the mothers

Table (4.6) showed that about most of the mothers 280 (74%) do not agree with the use of old razor blade in cutting their babies umbilical cord and most of the mothers agreed that the cut should be done with the use of a surgical blade 280 (76%) by the health worker. So also mothers used home remedies and appllied heat on the cord 323 (86%) to hasten the fall of their baby's umbilical cord.

Table (4.7): Mothers opinion on cultural practices regarding neonatal illness

Variables	Yes		No		No response	
	Freq	Percent	Freq	Percent	Freq	Percent
Exposing the baby to sun light (n=377)	145	38	176	47	56	15
Serving gripe water to the baby (n=377)	263	70	83	22	31	8.2
Administration of live oil (n=374)	68	18	145	39	61	16
Serving of palm carnel oil (n=374)	200	53	126	34	48	13
Administration of dates plam (n=377)	217	58	110	29	50	13
Administration of herbs when the baby is having skin problem. (n=376)	247	66	88	23	41	11

*The total number of the mothers differ in each variables based on the complete and correct response of the mothers

Table (4.7) revealed that almost half of the mothers 176 (47%) do not expose their babies to sun light when the babies skin turns yellow. The majority; 263 (70%) administered gripe water for the treatment of abdominal distension, 68 (18%) administered olive oil due to high body temperature, 200 (53%) applied plam kannel oil when the baby is having high body temperature and 217 (58%) administered date palm for the treatment of loss of appetite. More than half of them 247 (66%) also administered herbs (dauri) to their babies for the treatment of skin rashes.

Table (4.8): Mothers opinion regarding the care of the neonate eyes (n=375)

Variables	Yes		No		No response	
	Freq	%	Freq	%	Freq	%
Applying kajal on the baby's eyes to prevent evil eye	269	71.7	63	16.8	43	11.4
Tying black thread or bangles on the baby's hand or leg to prevent evil eye	81	21.6	255	68	39	10.4
Tying a thread with amulet (laya) to the baby's neck, waist or hand to prevent evil eyes	39	10.4	292	77.8	44	11.7

Table (4.8) The Table indicated that majority of the mothers 269 (71.7%) applied kajal (eye liner) on their babies eyes, more than half of them 255 (68%) did not use black thread on their babies hand and leg, and also most of the mothers 292 (77.8%) did not use thread with amulet (Laya) on their babies neck or waist for the prevention of evil eyes.

Table (4.9): Mothers opinion on cultural practices regarding surgical procedures on neonate

Variables	Yes		No	
	Freq	Percent	Freq	Percent
Which of the following do you perform on your baby? (n=388)				
Traditional uvulectomy	274	71	114	29
Male circumcision	369	95	19	5
Female genital mutilation	159	41	229	59
Tribal mark	67	17	321	83
Scarification mark	3	1	385	99
Blood letting	4	1	384	99

Table (4.9) showed that all most all the mothers 369 (95%) carried out male circumcision, about 274 (71%) carried out traditional uvulectomy, and 159 (41%) performed female genital mutilation.

Table (4.10): Summary of the distribution of mothers according to their opinion regarding neonatal health

Variables	Yes		No		No response	
	Freq	%	Freq	%	Freq	%
Mothers opinion on cultural belief regarding						
Neonatal bath (n=376)	146	39	190	51	40	10
Neonatal feeding (n=366)	219	60	133	36	14	4
Umbilical cord care (n=377)	140	37	215	57	22	6
Neonatal sickness (n=359)	190	53	121	34	48	13
The care of the neonate eyes (n=375)	130	35	203	54	42	11
Surgical procedures on neonate (n=388)	146	38	242	62	0	0

*The total number of the mothers differ in each variables based on the complet and correct response of the mothers

Table (4.10) showed the summary of mothers opinion on cultural belief regarding neonatal health in Igabi LGA of Kaduna State. The data indicated that mothers in Igabi LGA of Kaduna State agreed with the opinion of cultural neonatal feeding practice 219(60%) and cultural practices during neonatal sickness 190 (53%).

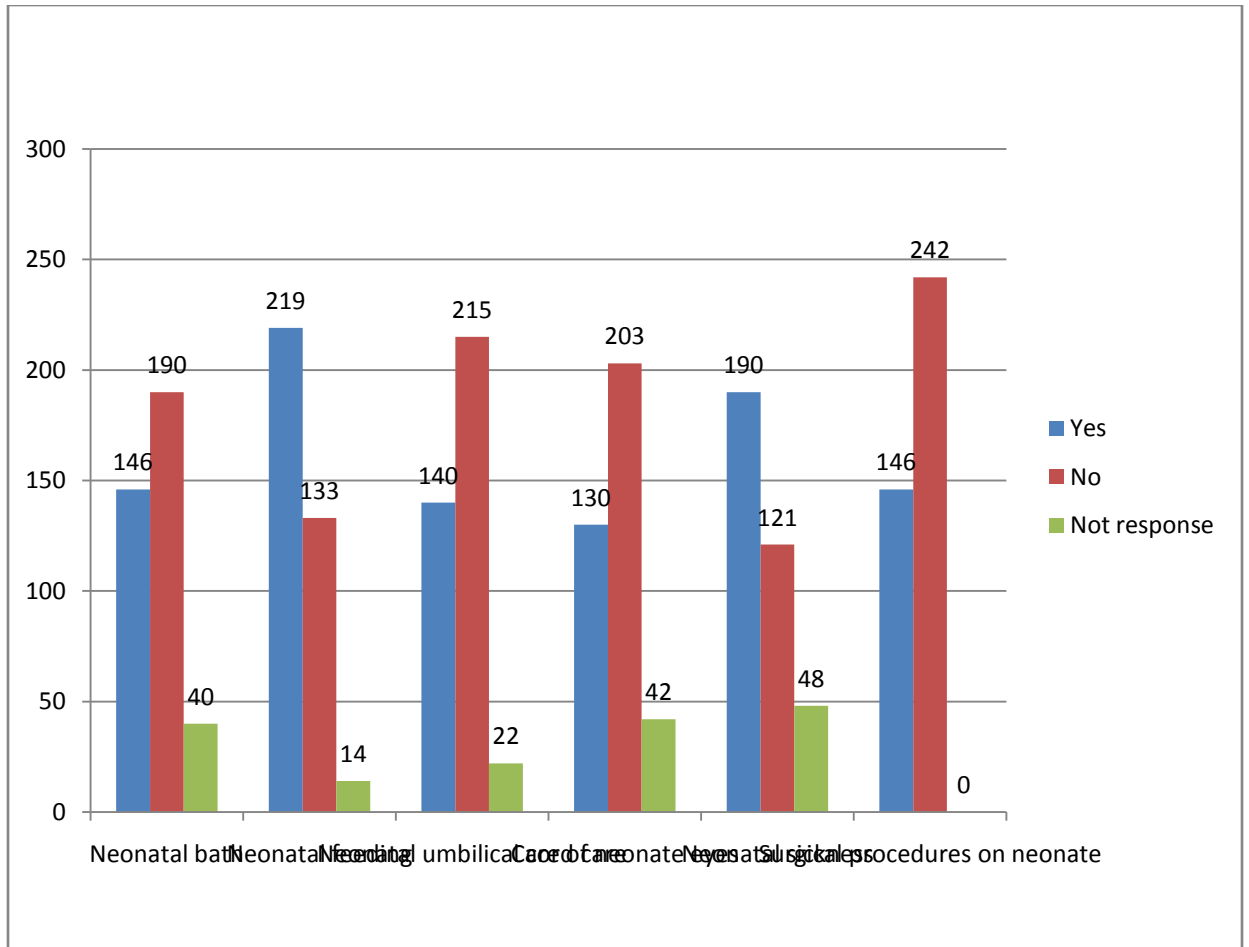


Fig (4.1) Summary of the distribution of mothers according to their opinion regarding neonatal health

Fig 4.1 revealed that mothers agreed with the opinion regarding neonatal feeding 219 (60%) and neonatal sickness 190(53%). However, mothers do not agree with the opinion regarding neonatal bath 190 (51%), neonatal umbilical cord care 215 (57%), care of the neonate eyes 203 (54%) and surgical procedures on neonates 242 (62%).

Section 3: Mothers reasons for performing the practice

Table (4.11):Reasons of cultural practices on neonateamong mothers n =314

Variables	Frequency (n=314)	Percentage
Psychological reasons	3	1.0
Economic factor	4	1.3
Religious practice	20	6.4
Personal perception	33	10.5
Past experience	107	34.0
Cultural belief	147	46.8

Table (4.11)revealed that the reasons why mothers engaged in cultural practices on their neonate were based on their cultural beliefs 147 (46.8%) and past experience104 (34%)

Section 4: Common harmful cultural practices on neonate among mothers.

Table (4.12): Common harmful cultural practices on neonate among mothers

Variables	Frequency (n=388)	Percentage
Traditional uvulectomy	247	63.6
Dauri bath and administration	211	54.4
Female genital mutilation	265	68.3

Table (4.12) revealed that the common harmful cultural practices on neonatal health among mothers in Igabi LGA of Kaduna State are female genital mutilation 265(68.3%)and traditional uvulectomy 247(63.6)

Section 5: Mothers awareness about the effect of harmful practices

Table (4.13) Mothers awareness about the effect of harmful cultural practice on neonate health

Awareness of mothers (n=376)	Aware		Not aware	
	Freq	%	Freq	%
Surgical Practices				
Traditional uvulectomy	121	32.1	255	67.8
Female genital mutilation	117	31.1	259	69.0
Scarification mark	287	76.3	89	24.0
Tribal mark	254	67.5	122	32
Non surgical Practices				
Dauri(herbal)bath and administration	186	49.4	190	50.5
Application of cowdung on neonate cord	258	68.6	118	31

Table (4.13) showed that most of the mothers were not aware about the effect of traditional uvulectomy 255(67.8%), FGM 259(69.0%), and Dauri (herbal) bath and administration 190 (50.5%) however, 287(67.5%) of the mothers were aware of the effect of scarification mark on their neonate, 254 (67.5%), tribal mark, and application of cowdung on their neonate cord to facilitate its fall 258 (68.6%).

B. Inferential Statistics

1. Showed the relationship between cultural belief and mothers ethnic group, age, marital status, family income, number of children and parity.
2. Showed the relationship between cultural practices and marital status, mothers age, ethnic group, family income, parity, number of children alive, parity and mothers religion

Table (4.14): Relationship between Cultural Belief and Sociodemographic Characteristics of Mothers at 0.05 level of significant

Cultural beliefs to	X ²	P
Mother age	4.6	0.05*
Ethnic group	21.1	0.02*
Number of children	7.3	0.06
Parity	6.7	0.06
Family income per month	9.3	0.18
Marital status	11.3	0.1
Religion	0.49	1.00

* Sig p=0.05

Table (4.14) showed the relationship between socio-demographic characteristics and cultural belief of mothers. The result revealed that there was a significant relationship between mothers age, ethnic group and cultural belief of mothers in Igabi LGA of Kaduna State.

So also the Table showed that there was no significant relationship between number of children, parity, family income per month, marital status, religion and cultural belief of mothers in Igabi LGA of Kaduna State.

Table (4.15); Relationship between Sociodemographic Characteristics and Cultural Practice of Mothers at 0.05 level of significant

Cultural beliefs to	X²	P
Marital status	6.48	0.005*
Ethnic group	21.22	0.018*
Number of children	10.5	0.015*
Family income per month	12.3	0.056*
Parity	9.33	0.025*
Place of delivery	10.77	0.003*
Mothers age	4.88	0.56
Religion	1.00	0.65

* **Sig p=0.05**

Table (4.15) showed the relationship between socio-demographic characteristics of mothers and their cultural practices. The result revealed that there was a significant relationship between cultural practices and marital status, ethnic group, family income, parity, number of children alive, parity and place of delivery of mothers.

The Table also revealed that there was no significant relationship between mother's age, mother's religion and cultural practices on neonatal health among mothers in Igabi LGA of Kaduna State.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

The purpose of this study was to assess cultural beliefs and practices mothers on neonatal Health in Igabi Local Government of Kaduna State.

Section 1; Socio-demographic Characteristics of Mothers

The findings of the study revealed that half of the mothers fall within the age range of 21 – 40 years. This indicated that most of the mothers in Igabi LGA were within their reproductive age group. They are mostly Muslims, Islam and Christianity as the main religion being practiced by the people in Igabi Local Government, although Islam is the dominant religion in the area. Most of the mothers were unemployed and they had secondary level of education. Their family monthly income ranges from below 9,000 – 31,000 naira. Majority of the mothers also belong to Hausa/Fulani ethnic group.

Implication of Finding

Most of the mothers in the study area were within their reproductive age range. They are mostly Muslims because Igabi LGA of Kaduna State is dominated by Muslims. They belong to Hausa/Fulani ethnic group because Igabi is located in the north central part of Kaduna State.

The saying that ‘poverty is a disease’ could be seen here as majority monthly family income is below average. Most of the mothers stated that they were unemployed and none of their family income is up to N 50,000 per month. This has severe implication to the mothers, as they can’t afford the enormous financial requirement to maintain a good health status even when they have the interest of keeping good health. These findings were

confirmed by McCarth and Maine, (1992) that the aggregate family income, occupation and education of family members could affect access to health care for the woman and her newborn baby.

Obstetric History of mothers

According to the finding of the study, it showed that about half of the mothers in Igabi LGA of Kaduna State had 1 – 4 pregnancies and had 1 – 4 children alive. So also most of the mothers in Igabi LGA of Kaduna State delivers their babies at home, which most of the deliveries were conducted by unskilled health provider. More than half of the mothers did not plan to deliver their babies at home and that for those that planned to deliver at home said that their reason was due to their past experience. This agreed with the study conducted by Lamina, (2005) titled a Survey of Home Delivery and Newborn Care Practices among Women in a Suburban Area of Western Nigeria The results of this study revealed that out of the 300 mothers that were interviewed, planned home deliveries were 200 (66.7%) and 100 (33.3%) were unplanned. Only 13.4% of deliveries had a skilled birth attendant present, and 47 (15.7%) mothers gave birth alone (Lamina, 2005). The study is also in-line with the report of NDHS, (2013) where it stated that the reasons for not delivering in the health facility in the north west of Nigeria was that according to the mothers delivery in the health facility was not necessary.

Implication of Findings

High-risk home delivery on newborn care practices are common in semi urban population in western Nigerian. Also in the northern part of Nigeria Igabi LGA of Kaduna State, based on the outcome of this study, there is need for community-based interventions

programmes to improve the number of families coming to health facilities and engaging a skilled attendant and hygiene during delivery.

Section 2: Mothers' opinions about cultural practices on neonatal care in Igabi LGA of Kaduna State.

Mothers in the area of study accepted the opinion of cultural practices on neonatal health and their reason was because it is a beneficial practice and it is carried out based on their cultural beliefs. This is in line with the study Cultural Practices and Beliefs on Newborn care among Mothers in a selected hospital of Mangalore Taluk India where most of the mothers' belief and practice culture on their newborn care.

Implication of the findings

In many parts of the country, mothers embark on certain cultural practices because they are ignorant of the basic information about the better way of caring for newborn. There is need for a multi-disciplinary approach at national and international level of advocacy and re-conscientization should be employed to expose the dangers of these cultural (negative) practices and the need to adopt orthodox practices. Health education and re-orientation of the mothers should be employed. Mothers should be well informed and educated. The importance of female education cannot be over-emphasized. There should be improvement on the National health system. That is, the National health system need to work to bring health care services to where the people are. This is because the majority of the people live in areas where general health care is inaccessible and the people give interpretations to the problems they cannot solve and make use of what they have. Finally, before health policies are formulated in Nigeria, the cultural and ethnic diversity of the

people should be put into consideration to ensure that there are no resistances to its implementation and that its purpose is achieved.

2-1 Opinion of mothers on cultural practices regarding feeding of neonate

In relation to the neonatal feeding, the findings of this study revealed that mothers in Igabi LGA of Kaduna State agreed with the opinion of cultural practice regarding neonatal feeding. The findings also revealed that some of the mothers fed their babies on the first day immediately after delivery with breast milk especially colostrum (first breast milk).

This study does not agree with the study which was conducted to describe the breast feeding and newborn care practice in reducing child mortality and morbidity in rural areas of Kengeri Bangalore. The findings showed that almost all the mothers initiated breast feeding, and few mothers used prelacteal feeds on their babies. This study emphasized the need for breast feeding intervention programs especially for the mothers during antenatal and postnatal check ups. The study is in accordance with a similar study Survey of Home Delivery and Newborn Care Practices among Women in a Suburban Area of Western Nigeria by Lamina, (2011) the result indicated that initiation rates of breast-feeding were 65.3% within one hour and 95.7% within 24 hours. This finding is not in-line with the study in Nepal where mothers in some communities believed that colostrum is a dirty milk and should be discarded, and where newborn babies were fed with cow or goat milk immediately after birth with the belief that the babies will become more intelligent (Yadav, 2007). The study is also in-line with a qualitative study conducted in 6 urban slum areas of Dhaka, Bangladesh, among 18

recently delivered mothers it was found that 40% of women gave honey while 16% of women gave sugar water soon after birth. It does not agree with Reshma and Sujath, (2014) in their study on cultural practices and beliefs on newborn care revealed that 31% of mothers gave prelacteal feeds soon after birth.

Implication of the findings

This showed that there was little adherence to the WHO (1996) recommendation of early and exclusive breastfeeding which should be initiated within 1 hour after child birth. This suggests that few mothers know the benefits of feeding colostrum to their newborns. However, the study revealed that more than half of the mothers administered glucose, honey, and warm water to evacuate the stool of the baby.

There is need for enlightenment programs in educating the mothers on the benefits of breast feeding especially the first milk (colostrum).

2-2 Opinion of mothers on cultural practices regarding bathing of the neonate

The findings of this study revealed that mothers in Igabi LGA of Kaduna State does not agree with the opinion of mothers regarding neonatal bath. However, about majority of the mothers in Igabi LGA of Kaduna State used traditional soaps in bathing their babies and throw them up after bath.

The findings of this study is not in line with the study on cultural practices and beliefs on newborn care among mothers in selected hospital of Mangalore Taluk, the result showed that the highest percentage of the mothers massaged the baby with oil before bath and the lowest percentage bath their baby with milk and adding a gold coin to the bath water of the baby. This study is also not in- line with the study on Domiciliary Newborn care

Practices in Bangladesh where the findings of the study revealed that babies were bathed on the first day within several hours of delivery and babies were bathed after putting turmeric to the body immediately after the delivery. Vernix caseosa is considered unholy (Darmstadt et al 2006). This study is also in accordance with the study conducted by Marah, (2011) on Household practices that influence National Survival in Asante – Akin North District of Ashanti Region. The study revealed that 84% of mothers used soap, sponge and warmwater with or without disinfectant (detol) to bath their newborn babies in order to protect them from falling sick, 7% bath their babies with herbal preparations (without knowing the content of the preparation), 4% smear their babies with sheabutter or with kaolin and 4% either bath their babies with Alata Semina (traditional soap) or give enema with the aim of protecting the newborns from falling sick. The findings also agreed with the study in Nepal, where the result revealed that newborn babies were considered dirty as they came out of their mother's womb, hence almost all newborn babies were bathed within the first hours of birth (Yadav, 2007).

Implication of the findings

The implication is that mothers in Igabi LGA of Kaduna State may be exposing their babies to skin infections, as they have no knowledge of the composition of the traditional soaps and its preparation etc. There should be awareness programs during ante-natal visit, delivery and post-natal care visit. This will go a long way in reducing incidence of problems associated with neonatal skin conditions.

2-3 Opinion of mothers on cultural practices regarding neonatal illness

According to the findings of this study. Mothers in Igabi LGA agreed with the opinion of cultural practices regarding neonatal illness. More than half of the mothers in Igabi LGA used home remedies like palm kernel oil, dauri (herbs), date, gripe water in the management of their babies indigestion, high temperature and in the treatment of skin rashes. This is in-line with the study of Marah, (2011) on Household practices that influence Neonatal Survival in Asante – Akin North District of Ashanti Region. The study revealed that mothers do not believe their newborns can be treated at the health facilities. They would rather treat their newborns with traditional medicine from the herbalist. Most of the mothers interviewed said they will visit the hospital upon recognition of the danger signs. They will buy “over-the-counter” drugs to treat their babies, or they will give first aid or enema.

The study is also in-line with the study which was conducted in Pemba Island, Tanzania. To describe newborn care practices and their potential impact on newborn care. The study estimated 32/1000 infants die within the first 28 days and revealed some traditional practices to treat illness such as exposing sick newborn babies to medicinal smoke from burning herds. In the study Traditional practice and oil massage of neonates in Bangladesh, it is unclear whether the practice of massaging newborns with coconut oil is harmful or beneficial. This study also agreed with a similar study Neonatal Home Care Practices in rural Egypt during the first week of life, Darmstadt *et al*, (2002) reported that 87% of mothers sought care for their neonates who had problems (fever, breathing problems and cold, or upper respiratory tract illness) only 17% were taken to trained providers, whereas, 38% were taken to homeopaths, and 37% were taken to village

doctors. Homeopathic medicines are believed to be mild, slow in action with no side effects, and especially suitable for children, particularly newborns, because of their sweet taste and ease of administration.

Implication of the findings

Mothers may also be exposing their babies to conditions like gastro-interitis, vomiting, allergic reactions etc. Some of these practices were carried out by mothers based on their past experience and cultural beliefs in the treatment of their newborn. Mothers should be discouraged by all means.

2-4 Opinion of mothers on cultural practices regarding care of the neonate cord

In relation to neonatal cord care, mothers in Igabi LGA of Kaduna State does not agreed with the opinion of cultural practices related to umbilical cord care. Most of the mothers in Igabi LGA of Kaduna State do not use old razor blade to cut their babies umbilical cord. The umbilical cord was cut with the use of a surgical blade by the health worker. Although 1/3 of the mothers used home remedies to hasten the fall of their baby's umbilical cord.

This study is in-line with the study of cultural practice on newborn where the result of the study revealed that substances applied on the cord stump include; ash, salt, mashed uncooked cocoyam, amoxicillin, tomato juice, fume from lantern/fire. This finding is also in accordance with the study conducted in Bangladesh Awasthi et al., (2008) where unhygienic cord care practices were prevalent and turmeric was the most common substance that was applied on the cord stump, mainly done by mothers. According to Darmstadt et al, (2006) reported in a similar study Neonatal Home Care Practices in rural Egypt during the first week of life, that in most of the cases, the

umbilical cord was cut with a razor blade for sterilization, and 71% applied nothing to the umbilical cord after cutting. The cord often is tied with dirty thread, such as thread used for sewing cloth. The tie typically is placed four finger widths away from the proximal end of the umbilicus. Little attention is paid to tying the cord, sometimes, the tie is loose with one knot or with no ties at all, which may result in bleeding. Earth of the local oven, ashes, lamp soot, powder, dry cow-dung, or oil may be put on the umbilicus, The umbilicus is sometimes heated to make it dry. Blood of the cord often is put into the baby's mouth and spread over the chest and back with the belief that this will increase bonding with mother.

Implication of the finding

This may suggest a low incidence of infection among newborns in the area. Although, some mothers used home remedies to hasten the fall of the umbilical cord. This does not follow the WHO, 2006 recommendation that that nothing should be applied on the cord stump, rather it should be washed with clean water and dried with clean cotton wool when soiled. In agreement with the WHO, local practices of putting various substances on the cord stump should be carefully examined and discouraged if they are found to be harmful and they should be replaced with those that are acceptable (WHO, 2006).

2-5 Opinion of mothers on cultural practices regarding care of the neonate eyes

With regards to mothers opinion on cultural practices regarding neonate eyes, mothers in Igabi LGA does agree with the opinion on cultural practices regarding neonate eyes. However, the findings revealed that 2/3 of the mothers in Igabi LGA of Kaduna State used Kajel or Kwalli (eye liner) on their babies eyes to beautify, treat eye problems

or to prevent evil eyes. This is in line with the study conducted in Mangalore Taluk India where most of mothers applied Kajal on the baby's eyes to prevent evil eye (Reshma and Sujatha, 2014). WHO, (2014) states that traditional practices are still going on by the primary caregiver such as the application of breast milk and other substance to treat eye infections. These have been showed to be ineffective in treating neonatal conjunctivitis and should not be used (WHO, 2014).

Implication of the finding

Mothers uses kagel on their babies eyes, which could expose the baby to conditions such as conjuntivities, obthalmia neonaturum, eye discharge, allergic conditions etc. Mothers should be advised to bring their babies to hospitals if they noticed any eye discharge, swelling or reddening of the eyes. The use of traditional eye liner should be clearly discouraged.

2-6 Opinion of mothers on cultural practices regarding surgical procedures on neonate

According to the result of this findings most of the mothers in Igabi LGA of Kaduna State have the opinion of performing surgical procedures like female genital mutilation, and traditional uvulectomy. These practitioners are actually carried out by traditional healers or lay individuals who double as barbers performing their acts with a sickle knife and other unsterilized instrument resulting to complications such as heamorrhage, airway obstruction due to aspirations, tetanus, hepatitis, risk for HIV, and septicemia (Ajibade, Okunlade and Kolade, 2013). A study on harmful traditional practices showed that about 3 children out of 30 are dying in Nigeria as a result of complications following traditional practices (Ajibade, et.,al 2013).

Implication of the findings

Cultural neonatal practices like traditional uvulectomy, female genital mutilation could lead to complications like HIV/AIDS, Hepatitis, Septicemia, Tetanus etc. This practice should be discouraged through health talks, community outreach in places of worships, market place and social centres.

Section 3: Reasons for cultural practices on neonate care among mothers.

The result also revealed that the reasons why mothers in Igabi LGA of Kaduna State engaged in cultural practice on neonate is mostly based on their cultural belief and past experience.

This is in line with a study on Socio-cultural Factors and attitudes affecting the Health Status of Rural Communities in Danmusa, Katsina State, Nigeria. The study identified reasons like cultural beliefs, poverty, illiteracy, age of mother at birth, unavailability of health human resources these affect the health status of mothers in DanmusaKatsina state (Uzobo, 2014). This study is in accordance with the a retrospective study conducted to determine home based newborn care practices in rural Makwanpur district Nepal. The result revealed that most of the existing cultural practices are based on deep seated traditional belief. This study does not agreed with one of the study conducted in the Eastern Tanzania, on Traditional uvulectomy and reported complications in under-five in Mkuranga District Pwani region. The aim of the study was to determine the practices, reasons and complications of traditional uvulectomy in under five children in relation to the level of education and tribe of the parent/guardian. This study concluded that cultural practices like traditional uvulaetomy was not associated with level of education and tribe.

Major reasons for traditional uvulectomy were upper respiratory tract infections, and major complications were bleeding and difficult in swallowing.

Implication of the practice

Mothers should be highly enlighten through the creation of awareness programes in understanding the effect of harmful cultural neonatal practice and discouraging their beliefs on harmful cultural practices.

Section 4: Common harmful cultural practices on neonate among mothers.

With regards to the common harmful cultural practices on neonate among mothers in Igabi LGA of Kaduna State. The findings showed that the common harmful practices on neonate include, traditional uvulectomy, dauri (herbal) bath and administration, female genital mutilation.

The findings of this study also is in-line with a retrospective study conducted by Manandhar et al., (2008) to determine home based newborn care practices in rural Makwanpur district Nepal. The result showed that many unsafe behaviour do exist in the area such as common use of untrained attendants, unsafe cord care and immediate bathing of the baby. The finding also agreed with the study conducted on harmful traditional practice, the study concluded that traditional uvulectomy is performed for neonate and children in the first or second year of life with the belief that the uvula is responsible for all throat problems including the suffocation of children in their sleep, sore throat, chronic cough, vomiting and diarrhea, rejection of breast milk by children, growth retardation and fever. The most common indication is throat pain, dyspsphagia (difficulty in swallowing), cough and loss of appetite.

Female circumcision (Female genital mutilation) is also a common harmful practiced in some communities in Nigeria, especially at birth or puberty or in the second trimester of pregnancy. It is common among some ethnic groups in Nigeria, the percentage of practice is high in some state like, Ondo (90- 98%), Delta (80- 90%), Plateau/Nasarawa (30- 90%), Kebbi (90- 100%, and Borno (10- 90%) (Gbefwi, 2004).

Implication of the practice

The implication of this findings is that cultural practices such as female genital mutilation and traditional uvulectomy in Nigeria is still an ongoing practice. These practices are still common, rampant and unchecked in our environment despite attempts made at discouraging it over the years. The traditional practitioners claim there are no risks associated with this practice despite the complications developed from patient. This could be due to lack of awareness about the essential newborn care practices which could have been gotten from their postnatal care visit.

Section 5: Mothers' awareness about the effect of harmful cultural practices on neonate health.

This study revealed findings on the awareness of mothers on surgical practices on neonate. Mothers in Igabi LGA of Kaduna State were aware of the effect of harmful cultural practices. However, the findings revealed that more than half of the mothers were not aware of the effect of traditional uvulectomy and female genital mutilation. The result also revealed findings on non surgical practices. The findings showed that mothers in Igabi LGA were aware of the effect of some harmful non surgical procedures like

scarification mark, tribal mark and application of cowdung on neonate cord. However, mothers were not aware of the effect of dauri bath and administration.

The findings of this study also is in-line with a retrospective study conducted to determine home based newborn care practices in rural Makwanpur district Nepal. The result showed that most people were unaware of the importance of immediate care of the newborn (Gurong, 2008).

Implication of the findings

This could be due to the lack of awareness about the effect of harmful cultural neonatal practices. The finding of this study exposes the harmful cultural practices of mothers on neonatal health in Igabi LGA of Kaduna State. Mothers will be encouraged to adopt positive behaviour change and the negative ones will be discouraged. Mothers will benefit through creation of awareness in understanding the negative effect of the practice. These will go a long way reducing neonatal morbidity and mortality in the community and the Local Government at large.

The findings of this study were analyzed using chi-square test X^2 and P which was used at 0.05 level of significant to test the relationship between mothers belief and their socio-demographic characteristics. The result revealed that there was a significant relationship between mothers age, ethnic group and cultural belief of mothers in Igabi LGA of Kaduna State. This indicated that mothers age, ethnic group influences mothers cultural belief on their neonatal health.

The findings also showed that there is no significant relationship between number of children, parity, family income per month, marital status, religion and cultural belief of

mothers in Igabi LGA of Kaduna State. This showed that number of children, parity, family income per month, marital status and mothers religion has no influence on mothers cultural belief on their neonate health.

The study also showed the relationship between socio-demographic characteristics of mothers and cultural practices on their neonate. The findings revealed that there is a significant relationship between cultural practices and marital status, ethnic group, family income, parity, number of children alive, parity and place of delivery of mothers. This indicated that marital status, ethnic group, family income, parity, number of children alive, parity and place of delivery of mothers has influence on cultural practice on neonatal health.

The Table also revealed that there is no significant relationship between mother's age, mother's religion and cultural practices on neonatal health. This showed that mother's age, mother's religion has no influence on cultural practices on neonatal health. These agreed with the study conducted by Reshma and Sujatha, (2014) on cultural practices and beliefs on newborn care among mothers in a selected hospital of Mangalore Taluk where one way ANOVA was performed to associate the cultural practices and beliefs with the selected demographic variables. The results showed that there is a significant difference in mean total score of the cultural practices across various types of family and Religion at 5% level of significance. All other variables there is no difference in the mean total score. There is an association between the type of family and religion with the cultural practices and beliefs on newborn care.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

In this chapter, the summary, conclusion and recommendations in the cultural beliefs and practices on neonatal health among mothers in Igabi LGA of Kaduna State is presented.

6.1 Summary

This study is aimed at assessing cultural beliefs and practices of mothers towards neonatal health in Igabi LGA of Kaduna State. A cross sectional descriptive study was used. The study populations were nursing mothers in Igabi Local Government Area of Kaduna State. The sample size used for the study was 400. However, 388 were used for data analysis. Multistage sampling and simple random sampling were used for the selection of wards. Convenience sampling was used for the selection of respondents in Primary Health Centers of the selected wards of Igabi LGA of Kaduna State. The instrument used for data collection was questionnaire which was structured. Data collected were analyzed using frequency Tables and percentages and chi-square test was used to test the relationship between the variables at 0.05 level of significance. The findings from this study showed that majority of mothers 314 (81.6%) in Igabi LGA of Kaduna State accepted the opinion of cultural practices on their neonate in order to improve their neonatal health. Their reasons were based on their cultural belief 147 (46.8%) and past experience 104 (34%). The commonest harmful cultural practices on neonatal health among mothers in Igabi LGA of Kaduna State include female genital Mutilation 265(68.3%), traditional uvulectomy 247(63.6), and the use of dauri (herbal) bath and administration 211(54.4%). Mothers in Igabi LGA of Kaduna State were aware

of the effects of some harmful cultural practices on their neonate; however, they were not aware of the effect of female genital mutilation 258(68.6%), traditional uvulectomy 255(67.8%), and dauri (herbal) bath and administration 190 (50.5%). It was therefore recommended that cultural neonatal practices should be investigated by the ministry of health and non governmental organizations, the useful ones should be preserved while the harmful ones should be discarded by health education and effective awareness programmes on early neonatal care among mothers.

6.2 Conclusion

On the basis of the result and the objectives of the study, the following conclusions were drawn.

1. The mothers in Igabi Local Government of Kaduna State accepted the opinion of cultural regarding neonatal illness and feeding.
2. Cultural beliefs and past experiences of respondents are the main reasons for cultural practices on neonatal health care in Igabi Local Government of Kaduna State.
3. Female genital mutilation, traditional uvulectomy, the use of dauri (herbal) bath and administration are some of the common harmful cultural practice performed by mothers on their neonate
4. Mothers in Igabi LGA of Kaduna State are not aware of the effect of female genital mutilation, traditional uvulectomy, dauri (herbal) bath and administration on their neonate.

6.3 Recommendations

1. More attention should be given about harmful cultural practices by community health nurses in the communities. Cultural neonatal practice should be investigated by health workers especially the community health nurses, the useful ones should be preserved while the harmful ones should be discouraged. This will go a long way in changing mothers opinion regarding cultural neonatal care.
2. The community health workers should educate the women more on early neonatal care especially on feedin practices and care during sickness, not only when they go for antenatal care, but also in the form of campaigns, at market places, mosques, and churches. Men should equally not be left out as they are the decision makers in the family. These will change their beliefs on neonatal health care.
3. Female genital mutilation, traditional uvulectomy dauri (herbal) bath and administration on neonate should be discouraged at all level through enligtement programmes, most especially to mothers, fathers, traditional healers and traditional bath attendants. This will go a long way in reducing the incidences of harmful cultural practices performed by mothers on their neonate.
4. There should be effective awareness programmes on harmful neonatal practice. The programmes should be made necessary and organized by health workers, community health actors such as community health nurses, mothers, mothers-in-law, husbands, and traditional birth attendants should also be taken into consideration in intervention programmes.

6.4 Suggestion for Further Studies

Further studies needs to be carried out on;

1. The prevalence of female genital mutilation (FGM) and related complications among neonates in Igabi LGA of Kaduna State.
2. The incidence of traditional uvulectomy and related complications among neonates in Igabi LGA of Kaduna State should also.

REFERENCES

- Abasiekong, E. M. (2010). *The Changing Faces of Rural Nigeria: Change and Continuity*. Uyo, Nigeria: Abaam Publishing Co.
- Abdulaziz, S. S. (2009). Cultural needs assessment. Avail at <http://www.nurse.saida.com>. Bursesaida's Blog (accessed 6th June, 2016).
- Abia, A.A. (2012). African Beliefs Systems and Healthy Living. *International Journal of Culture and Human Development*, ISSN:2306-9007
- Adesina, S.K. (2013). Post Opp Instructions for uvulectomy. Avail at www.yvgsz.qughw.mobi (yvgsz.qughw.mobi/6N) BOG (accessed 10th June, 2016).
- Adeyinka, D., Oladimeji O., Adeyinka F., and Aimakhu C.,(2008). Uptake of childhood Immunization Among Mothers of under-five in Southwestern Nigeria. *The Internet Journal of Southwestern Nigeria. The Internet Journal of Epidemiology*, 7(2) :1-9.
- Ajibade, B.L, Okunlade, J.O, Kolade, O.A. (2013) Harmful cultural practices perceived effects of traditional uvulectomy on under-five children in Jigawa State Nigeria. *Journal of Dental and Medical Sciences (IOSR-JDMS)* Volume 9. Avail at www.iosrjournals.org(Retrieved on 6th June, 2016)
- Adolescent and Youth Reproductive Health (AYRH) (2005). Harmful Traditional Practices avail at www.open.edu/.../mod/...view php?id (retrieved on 6th June, 2016).
- Adolescent and Youth Reproductive Health Module 5 (AYRH) Harmful Traditional Practices available at www.open.edu/openlearnworks/mod/oncontent/view.php. (Retrieved on 6th June, 2016)
- Alam, M.A., Sultana, N.A., Mullany, L.C., Teela, K.C. and Khan, N.U.Z (2008). Newborn Umbilical Cord and Skin Care in Sylhet District. *Journal of perinatology*, 28: 61-68.
- Ambe, J.P., Bello, M., Yahaya, S.J. and Omotara, B.A. (2009). Umbilical cord care practices in Konduga Local Government Area of Borno State, Nigeria. *The Internet Journal of Tropical Medicine*,5(2): Pp246.
- Ameh, C. O. (2002). Harmful traditional practices in Nigeria and measures for eradication: An educology of home education. *International Journal of Education and Psychology*, 16(1): 1-10.

- Awasthi, S., Verma, T. and Agarwal, M. (2006). Danger Signs of Neonatal Illnesses: perceptions of caregivers and health workers in northern India. Avail at www.who.int/entity/bulletin/volumes/84/10/05-029207pdf (accessed on 20th April, 2016).
- Baqi, A.H, Darmstadt, G.L, Williams, E.K, Kumar, V, Kiran, T.U, Danwar. D, Srivastava, V.K, Ahuja, R, Black, R.E and Santosham, M. (2006). Rating, timing and causes of neonatal deaths in rural India: Implications for neonatal health programmes. *Pubmed-NCBI*. Available at <https://www.ncbi.nlm.nih.gov/pubmed/17128340>. Accessed on 20th April, 2016.
- Belief definition by Babylon's free dictionary available at dictionary.babylon-software.com/beliefs (accessed 2nd April, 2016).
- Beser, A., Topcu, S., Coskun, A., Erdem, N., Gelisken, R. and Ozar, D. (2010). Traditional child care practices among mothers with infants less than 1 year old. *Deuhyo Ed*, 3(3): 137-145.
- Bhandari, N., Bahl, R., Mazumdar, S., Martines, J., Black, R. and Bhan, M. (2003). Effect of community based promotion of exclusive breastfeeding on diarrhoeal illness and growth: a cluster randomized controlled trial. *Pub Med India*. 361(9367): 1418-1423.
- Breast feeding practices and newborn care in rural areas. A descriptive cross sectional study, 2009. *Indian Journal of community medicine*, 34(3): 243-246.
- CARLA, (2017). defination of culture. The university Internal center Minneapolis MN 554141 avail at Convenience sampling; avail at dissertation. Laerd.com/convenience (retrived on 6th/June, 2016).
- Darmastadt, G. L., Hussein, M. H., Winch, P. T., Haw, R. H., Lamina, M. E. L., Sais, M. A., Gipson, R. F. and Santo, S. M. (2007). Neonatal home care practices in rural Egypt during the first week of life. *Trop Med Int health*
- Devkota MD, Bhatta MR, (2011). Newborn care practices of mothers in a rural community in Baitadi, Nepal. *Health Prospect*, 10: 5-9.
- Fikree, F. F., Tazeen, S. And Ali, J. M. (2005). Durocher and Mohammed Hossein Rohbar, Newborn care practices in Low Socio-economic Settlements of Karachi. *Pakistan Social Science Direct and Medicine*, 60:911-921.
- Gary, L., Darmstadt, U. S., Zohra, P. and Nazma, K. (2006). Review of Domiciliary newborn care practices in Bangladesh. *Journal of Health Population NUTR*.ISSN 1606-1997

- Gary, L., Darmstadt, U. S., Mohammed H. H., Pater W., Rachel, A., Haws, M. L., Mohsen, A.E., Reginalf, F., G. and Mathuram, S.(2007). Neonatal home care practices in rural Egypt during the first week of life. *A European Journal TMIH*, Pp1365-3156.
- Gbefwi N. B. (2004). *Traditional Practce, Health Education and Communication Strategies*. Lagos: West African Book Publishers Ltd. Pp34-36
- Gebrekistos, A. Atsede, F. And Buruh, G. (2013). Magnitude and Reason for Harmful Traditional Practices among Children Less Than Five years of Age in Axum Town, North Ethopia. *International Journal of Pediatrics*. Available at <http://dx.doi.org/10.1155/2014/169795>
- Ghana Statistical Service (GSS) (2008). Ghana Health Service (GHS), MEASURE DHS and Macro International, (2009) Ghana Demographic and Health Survey. Preliminary Report, Calverton, Maryland.
- Gurong, G. (2008). Practice on Immediate care of newborn in communities of Kalilali district Nepal *Medical College Journal*, 10(1): 41-44
- Idehen, C. O. (2007). Insights into Benin Traditional methods of Disease Prevention. *Journal of Pan- African Studies Nigeria*, 1(8): Pp118.
- Leicester, J. (2017) belief definition avail at [watch?v=dc14jdqjoiu](http://www.youtube.com/watch?v=dc14jdqjoiu) (accessed 5th January, 2017)
- Joannah, Q., Rachel, T and Paul, (2007) (Traditional beliefs and practices in the postpartum period in Fujian Province, China: A quantitative Study. *Bio Med Central Pregnancy and Childbirth*, 7(1): 8 Doi:10.1186/1471-2393-9-8 (Pubmed)
- Kashsu, G., Atesede, F. and Gerezgiher, B. (2013). Magnitude and reasons for Harmful traditional practices among children less than 5 years in Axun Town. *Biomed Center LMD* avail at <http://creativecommons.org/licenses/by/2.0>
- Kashsu, G., Atesede, F. and Mesfin, A. (2013). Magnitude and reasons for Harmful traditional practices among children less than 5 years in Axun Town. *International Journal of Pediatrics of North Ethiopia*. PMC4089850
- Kesterton, A. J. and Eleland, J. (2009). Neonatal care in rural Karnataka; Healthy and harmful practices. The potential for change and harmful practices, the potential for change. *BMC Pregnancy child birth* DOI: 10.1186/1471-2393-9-20
- Khadduri R., Marsh D. R., Rasmussen, B., Nazir, R. and Darmstadt, G. L. (2008). Household knowledge and practices of newborn and maternal health in Haripur district, *Pakistan Journal of Perinatology*, available at <http://cat.inist.fr/?aModele=affiche&Nandcpsidt=20473045> (accessed on 2nd May 2016).

- Kim. A. Z. (2015). What is culture-definition. Live Science contributed available at www.livescience.com/21478.
- Lancet, (2008). Equity in use of home-based or facility-based skilled obstetric care in rural Bangladesh: an observational study.
- Lamina, M. A., Sule-Odu, A. O. and Jagun, O. E. (2004). Factors militating against delivery amongst patients booked in OOUTH, Sagamu. *Nigerian Journal of Medicine*,13(1): 52-55.
- Lamina, M.A., (2011). A survey of home delivery and newborn care practices among women in a suburban area of western Nigeria. *International scholarly network ISRN Obstetrics and Gynecology* . Nigeria
- Lawn, J. E., Brian, J., McCarthy, S. and Rae, R. (2001). The Healthy Newborn: A Reference Manual for Program Managers.CARE-CDC Health Initiative, Atlanta.
- MacCarthy, J. and Maine, D. (1992). A framework for Analyzing the Determinants of Mortality Studies in Family Planning. Population Council. *Research Gate*, 23(1): 23-33
- Madhu, K., Chowdary, S.and Ramesh, M. (2009). Breast feeding Practices and newborn care in rural areas. *Indian Journal of community medicine*, avail www.biomedcentral.com/1471-2393/9/54.
- Manandhar, D. S., Osrin, D., Shrestha, B. P., Mesko, N., Morrison, J., Tumbahangphe, K., Tamang, S., Thapa, S., Shrestha, D., Thapa, B., Shrestha, J. R., Wade, A., Borghi, J., Standing, H., Manandhar, M. and Costello, A. M. (2008). Members of the MIRA Makwanpur trial team: Effect of a participatory intervention with women's groups on birth outcomes in Nepal: *cluster Randomised controlled trial*, 364(9438): 970-979.
- Marah, A. (2011). Household practices that influence neonatal survival in Asante Akin North District of the Ashanti Region, [http:// dspace. knust. edu. gh: 8080/ jspui/ bitstream/123456789/107/1/Thesis.pdf](http://dspace.knust.edu.gh:8080/jspui/bitstream/123456789/107/1/Thesis.pdf) URL
- Marshall, S. (2007). avail at [www.media- studies.ca/articles/culture](http://www.media-studies.ca/articles/culture). Malaspina University College Media Studies (accessed on 6th July,2016).
- Merriam Webster dictionary (MWD) (1828) available at www.meriam-webster.com/dictionary/belief(accessed on 6th July,2016).
- Mosiur, R., Syed, E., Mdadul, H., Sarwar, Z. And Ohidu, I.(2011). Non Institutional Births and Newborn Care practices among Adolescent Mothers in Bangladesh. *Journal of Obsteteric, gynecologic and neonatal nursing*, 40(3): 262-273.

- Mrisho, M., Schellenberg, A., Mushi, A., Obrist, B., Mshinda, H. and Tanner, M. (2008). Understanding home-based neonatal care practice in rural Southern Tanzania. *Trans. R.Soc. Trop. Med. Hyg.* 102:669-678. Avail at <http://www.ncbi.nih.gov/pubmed/18513769> (accessed on 6th July, 2016).
- Myles a text book of midwives, 2003. 14th Edition Elsevier British Library Publication Pp736-739
- Nigeria Demographic and Health Survey (NDHS) (2013). Calverton MD: National Population Commission and ORC macro International. Abuja: Government Printers.
- Nova, S. (2005). A cultural competence guide for primary health care professional. Department of Health Primary Health Care Section.
- Oesterggaard, M. Z., Inoue, M., Yoshida, S., Mahanani, W. R., Gore, F. M. and Cousens, S. (2011). Neonatal mortality levels for 193 countries in 2009 with trends since 1990: A systematic analysis of progress, projections, and priorities. *PLoS Medicine*, 8. doi:10.1371/journal.pmed.1001080. [PMC free article] [PubMed]
- Ojua, T. A. and Omono, C. (2012). African Cultural Practices and Health Implications for Nigeria Rural Development. *International Review of Management and Business Research*, 2(1): 23-36.
- Opara, D.B, Tamunopriye, J. Doris, A. D, Balafama, A. A-H, (2012). Newborn cord care practices amongst mothers in Yenagoa Local Government Area, Bayelsa State. *International Journal of clinical medicine*. Available at <http://dx.doi.org/10.4236/ijcm>.
- Omotosho, (2010) African cultural practices and health implications for Nigerian Rural areas avail at www.irnbrjournal.co/papers/13675724.
- Onyeabochukwu, D. (2007). Cultural Practices and Health: The Nigerian Experience *Medikka Journal of the University of Nigeria*, Enugu Campus, Enugu (ISSN 0331-1643)
- Orin, D., Tumbahanghe, K.M., Shrestha, D., Mesko, N., Shrestha, B.P., Mamandhar, M.K., Standing, H., Manandhar, D.S. and Costello, A.M. (2002). Community based study of care of the newborn infant in Nepal, *BMJ Nova*, 325(7372): Pp1063
- Panul, D. and Deadihic, (2007). Nursing Jaypee Brothers Medical Publishers LTD new Delhi. Pp66
- Parlato, R., Darmstadt, G. and Tinker, A. (2004). Qualitative Research to Improve Newborn Care Practices. *Saving Newborn Lives: Tools for Newborn Health*. Washington DC

- Peace Ibo Opara, Tamunopriye Jaja, Noris Atibi Dotimi, Balafama Abinye (2011). *Internal Journal of clinical medicine* avail <http://dx.doi.org/10.4236/ijcm.2012.31.004>
- Quizlet, I. (2017). culture – avail at <https://quizlet.com/...ap-human-geo-topi> (Retived 2nd January, 2017).
- Reshma, and Sujatha, R. (2014). 12 Lecturer, Professor and HOD, Department of Pediatric Nursing Nitte Usha Institute of Nursing Sciences, Nitte University, Deralakatte, Mangalore - 575 018, Karnataka, India. *NUJHS*, 4(2): 2249-7110.
- Rogers, E. M. (1995) Diffusion of innovations, New York, Free Press, Pp4.
- Save the Children Federation (SCF) (2001). State of the World's Newborns: A Report from Saving Newborn Lives. Washington, DC.
- Seidel, R. (2005). Behaviour change perspectives and Communication Guidelines on Six Child Survival Interventions, A joint publication of the Academy for Educational Development and the John Hopkins Bloomberg School of Public Health/Center for Communication Program with support from the United Nations Children's Fund.
- Schwitzgebel Eric, (2006) Belief in Zalta, Ed ward, the stanford Encyclopedia of philosophy Stanford, CA: The metaphysics Research Lab (accessed on 6th June, 2016).
- Six harmful traditional practices on diseases available at www.nairaland.com/1875357/six-harmful.tradtional.pr(Retrieved on 7th March, 2016)
- Shams, E. L., Arifeen, L. C. M., Rasheduzzaman, S. I. M., Syed, M. R.M., Radwanur, R. T., Nazma, B., Ahmed, A., Gary, L. D., Mathuram, S., Robert, E. B. L. and Abdullahi, H. B.(2012). The effect of cord cleansing with chlorhexidine on neonatal mortality in rural Bangladesh: A cmmunity based culster randomized trial. Avail at www.thelancet.com/journals/lancet/article/piss(accessed on 5th January, 2016)
- Tinker, A. and Ransom, E. (2003), Healthy Mothers and Healthy Newborns: ‘The Vital Link’ (Washington, DC: Population reference Bureau)
- Turner, L.W., Hunt, S.B., DiBrezza, R. and Jones, C. (2004). Design and implementation of an Osteoporosis Prevention Programme using the Health Belief Model. *American Journal of Health Studies*, 19(2): 115-121.
- Uzobo, E., Ogbanga, M. M. and Jack-Jockson, T.C.B. (2014). The implications of the feminization of God among the Ijaw people of Nigeria. *African Journal of social science*,4: 99-108.

- Vinod, K. P. (2005). Current State of Newborn Health in Low income countries and the way forward. *Seminars in Fetal and Neonatal Medicine*, 11: 7-14.
- Waiswa, P. and Petersons, T. G.(2010). Poor New born Care Practices ; A Population based Survey in Eastern Uganda. *BMC Pregnancy and Childbirth*, 23(1):1-10.
- Woodruff, A.W., Grant, J., El-Bashir, E.A., Baya, El., Yugusuk, A. Z. and El-Suni, A. (1984). Neonatal tetanus: mode of infection, prevalence, and prevention in Southern Sudan. linkinghub.elsevier.com/retrieve/pii/S0140673684904239.
- Woodruff, A. w. and Grant, J.El.(2008). cord separation time. *Umbilical cord care* OA, El mile PO avail at www.njpaediatrics.com/v38nn3/72262157 (accessed on 5th March, 2016).
- World Health Organization (WHO), (1996). Perinatal mortality; a listing of available information. FRH/MSM. Geneva. Pp96-97.
- World Health Organization (WHO) (2006). Essential Newborn Care Manual. Geneva.
- World Health Organization (WHO), (1999). Care in Normal Birth: A Practical Guide. WHO Geneva.
- World Health Organization (WHO), (2002). Protecting, Promoting and Supporting Breast-feeding: The Special Role of Maternity Services, A Joint WHO/UNICEF Statement.
- World Health Organization (WHO), (2006). Neonatal and Perinatal Mortality; Country, Regional and Global Estimates.
- Yadav, S. (2007). Newborn care: traditional practices in Nepal. Archive student. [bmj.Com /issues/07/09/life/308.pdf](http://bmj.Com/issues/07/09/life/308.pdf), (accessed on 2nd/June, 2017).
- Yamane Taro, (1967) Statistics, an introductory analysis, 2nd edition. New Yourk: Harper and Row
- Yinger N.V and Ransom E.I, (2003). Why Invest in Newborn Health? Available at http://www.prb.org/pdf/whyInvestnewborn_Eng.pdf and accessed on 2/6/2017.

APPENDIX 1

**DEPARTMENT OF NURSING SCIENCE
FACULTY OF MEDICINE
AHMADU BELLO UNIVERSITY, ZARIA
QUESTIONNAIRE**

Dear Sir/Ma,

**CULTURAL BELIEFS AND PRACTICES OF MOTHERS TOWARDS NEONATAL
HEALTH IN IGABI LGA OF KADUNA STATE**

It is acknowledged that your time is valuable and precious. However, your participation in this study, which takes 10 – 15minutes of your precious time, would decide the success of this study.

I am a post graduate student in department of Nursing Science, Faculty of Medicine, Ahmadu Bello University Zaria, and currently undergoing MSC nursing degree. I am conducting a survey on Cultural Beliefs and Practice of Mothers towards Neonatal Health in Igabi LGA of Kaduna State.

Thank you for taking your time to fill in this questionnaire. Your responses will remain anonymous and confidentiality and no information that could reveal your identity will be used. All the data that will be gathered will be strictly used for academic purposes only.

I hope to be able to receive your co-operation. Thank you in anticipation of your response. If you are interested in finding out the outcome of this study, you can contact me through email: saadatumsany@gmail.com or 08106208390/08022601455

Thank you for your time.

Yours sincerely,

Mohammed Sani Saadatu

SECTION A – SOCIODEMOGRAPHIC CHARACTERISTICS

PERSONAL HISTORY

Tick (✓) the appropriate box indicating choice of options below.

1. Mothers age in years
 - ≤ 20 years
 - 21 – 30 years
 - 31 – 40 years
 - 41 – 50 years
 - ≥ 51
2. Religion: a. Islam () b. Christianity () c. Others
3. Marital status: a. Single () b. Married () c. Seperated ()
d. Widower ()
4. Occupation of mothers: a. Unemployed () b. Employed ()
5. Level of education of mother: a. Primary () b. Secondary () c. Tertiary () d. Non ()
6. Family Income
 - a. $\leq 9,000$ ()
 - b. 10 – 31,000 ()
 - c. ≥ 32 ()
 - d. Others specify ()
7. Ethic group a. Hausa/Fulani () b. Yoruba () c. Igbo () d. Others
(Specify).....

OBSTETRIC HISTORY

8. Parity: a. 1 () b. 2 () c.3 () d. 4 above ()
9. Number of children alive a. 1 () b. 2 () c.3 () d. 4 above ()
10. Age of last child
- a. 1 day -1 month
 - b. 1months – 6months
 - c. \leq 6months- 1 year
 - d. \geq 1year
- 11 place of delivery? A. At home () b. In hospital () c. Others (specify).....
- Who conducted the deliveries? a. Skilled health provider (Nurses, Midwives,Dr, Chew) ()
- b. Unskilled health provider (TBA, Auxillary Nurse) ()
- 12 Did you plan to deliver at home? a Yes () b No ()
13. Reasons why you prefer to deliver at home(Tick as many as apply)
- a. Past expeirence ()
 - b. Economic issue ()
 - c. Emergency condition ()
 - d. Attitude of health workers ()
 - e. Feel secured at home ()
- 14 Do you believe in cultural practiceson neonatal care?
- If yes why?
- If no why?

General Instruction:

Please read each of the following statements carefully. Then tick (√) for each, whether yes or no. You can skip statement if you have no idea.

Cultural Practices regarding Neonatal Bath

S/N	STATEMENT	YES	NO
1	Massaging the baby with oil before bath		
2	Giving bath to baby with milk		
3	Bathing the baby 3 times a day		
4	Using traditinal soaps in bathing the baby		
5	Throwing the baby up after bath		
6	Applying concocision on the babies body before bath.		

Cultural Practices Regarding Feeding of Neonate

S/N	STATEMENT	YES	NO
1.	Fed baby immediately after delivery with breast milk		
2	Fed on the first day with glucose		
3	Breast fed the baby		
4	The baby was fed on the first day with honey		
5	The baby was not fed on the first day		
6.	Feeding the baby with formula milk		
7.	Discarding the colostrum (first milk)		
8.	Giving hot water to evacuate the stool		
9.	Giving home remedies for digestion like		
	a. Garlic		
	b. herbal leaves		
	c. Olive oil		
	d. Shea butter		
	e. Others (specify)		

Cultural Practices on Umbilical Cord Care

S/N	STATEMENT	YES	NO
1	Old razor blade was used to cut the umbilical cord by the traditional birth attendant		
2	Old razor blade was used to cut the umbilical cord by the traditional birth attendant		
3	Surgical blade was used to cut the umbilical cord by the nurse/midwife/ chew in the hospital		
4	What do you apply on the umbilical cord to hasten the fall of the umbilical cord of the baby		
	a. Ashes		
	b. Cow dung		
	c. toothpaste		
	d. powder		
	e. e. Vaseline		
	f. Others (Specify).....		
5	Applying heat on the cord to make it dry		

Cultural Practices on neonate during sickness

S/N	STATEMENT	YES	NO
1	Exposing the baby to sun light when the baby's skin turns yellow		
2	Giving sugar water to the baby during jaundice		
3	Administration of gripe water when the baby is vomiting		
4	Administration of olive oil when the baby is having diarrhea		
5	Application of plumcarnel oil when the baby is having high temperature		
6	Administration of dates in the treatment of loss of appetite		

7	Administration of herbal to the baby when the baby is having skin problems like napkin rash		
---	---	--	--

Cultural Practices on Neonate Eyes

S/N	STATEMENT	Yes	NO
1	Applying kajal on the baby's eyes to prevent evil eye		
2	Tying black thread or bangles to the baby's hand or leg to prevent evil eye		
3	Tying a thread with amulet(laya) to the baby's neck, waist or hand to prevent bad eyes		

Cultural Practices on Surgical procedures among Neonate

S/A	STATEMENT	Tick (√) in the appropriate
1	Which of the following do you perform on your baby	
	a. Traditional uvulectomy	
	b. Male circumcision	
	c. Female genital circumcision	
	d. Tribal mark	
	e. Others (Specify).....	

**SECTION C – THE REASONS OF PERFORMING CULTURAL PRACTICES
ON NEONATE AMONG MOTHERS**

General instruction:

**Please read each of the following statements carefully. Then tick (√) for each, either
yes or no**

Mothers reasons of cultural practices on neonate

Variables	Yes	No
1. Religious practice		
2. Past experience		
3. Personal perception		
4. Economic factor		
5. Psychological reasons		
6. Cultural belief		
7. Others specify		

**SECTION D: COMMON HARMFUL CULTURAL PRACTICES ON NEONATE
AMONG MOTHERS**

List the common harmful cultural practices in your area.

S/N	TYPES OF CULTURAL PRACTICES	PERFORM BY WHO
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

11.		
12.		
13.		
14.		
15		

SECTION E- MOTHERS AWARENESS ABOUT THE EFFECT OF HARMFUL CULTURAL PRACTICES ON NEONATAL HEALTH CARE

Please read each of the following statements carefully. Then tick (√) for each, the variable you are aware that it is a harmful cultural practice on neonate

Awareness of mothers about the effect of harmful cultural practice on neonate health

Variables	Yes (Aware)	No (Not aware)
1.Traditional uvulectomy		
2.Female genital mutilation		
3.Scarification mark		
4.Application of cowdung on neonate cord		
5.Tribal mark		
6.Dauri bath and administration		
7.Force Feeding		
8.Others specify		

APPENDIX 2

IGABI LOCAL GOVERNMENT WARDS, POPULATION AND PRIMARY HEALTH FACILITIES

WARDs	HFS	TOTAL POP	<1 Yrs
AFAKA	PHC MANDO	11,740	470
AFAKA	PHC AFAKA	12,000	480
AFAKA	PHC KUTUNGARE	9,790	392
AFAKA	ANNUR MC	3,680	147
AFAKA	PHC IFIRA	4,990	200
		42,200	1688
BIRNIN YERO	CHC JAJI	14,832	593
BIRNIN YERO	AFCSJ JAJI	8,580	343
BIRNIN YERO	H/C B/YERO	2,704	108
BIRNIN YERO	H/C LABAR	5,127	205
		31,243	1250
IGABI	PHC IGABI	11,533	461
IGABI	PHC SHEKA	7,931	317
IGABI	PHC ASHEHU	7,519	301
		26,983	1079
RIGACHIKUN	PHC KURMI KADUNA	3,192	128
RIGACHIKUN	PHC LIKORA	3,805	152
RIGACHIKUN	PHC BARAKALLAHU	6,769	271
RIGACHIKUN	PHC ZAURE	4,845	194
RIGACHIKUN	PHC RIGACHIKUN	8,086	323
RIGACHIKUN	MH/NDC	5,700	228
RIGACHIKUN	NTI STAFF CLINIC	1,107	44
		33,504	1340
RIGASA	PHC MAHUTA	14,754	590
RIGASA	PHC MIYATTI	55,427	2217
RIGASA	PHC K/KWALTA	21,994	880
RIGASA	GH RIGASA	26,313	1053
RIGASA	PHC NARIYA	24,650	986
RIGASA	PHC H/DANMANU	21,300	852
RIGASA	CENTRAL HOSP.RIGASA	3,345	134
RIGASA	NMH RIGASA	3,345	134
RIGASA	MARABA N&C	3,345	134
RIGASA	PHC TARO TARO	11,825	473
RIGASA	AISHA AL- ANSARIYA	4,326	173

RIGASA	FAHAD MEMORIAL	1,248	50
RIGASA	KWARTE HC	2,000	80
RIGASA	MALAMAWA	2,000	80
		195,872	7835
ZANGON AYA	H/C IRUGA	2,138	86
ZANGON AYA	H/CLAMBAN ZANGO	2,762	110
ZANGON AYA	PHC MANGI	2,575	103
ZANGON AYA	PHC AUDI	2,681	107
ZANGON AYA	H/C MALAMAI ANG-	1,610	64
ZANGON AYA	H/C T/WADA MANGI	2,310	92
ZANGON AYA	H/C KAMFANIN ZANGO	2,576	103
ZANGON AYA	H/C KIGO	2,453	98
ZANGON AYA	NHIS Z/AYA	3,106	124
		22,211	

APPENDIX 3

LETTER OF INTRODUCTION

APPENDIX 4
ETHICAL CLEARANCE

APPENDIX 5

INFORMED CONSENT FORM

INFORMATION SHEET

Title of the research: CULTURAL BELIEFS AND PRACTICES OF MOTHERS

TOWARDS NEONATAL HEALTH IN IGABI L.G.A OF KADUNA STATE

Name(s) and affiliation(s) of researcher(s) of applicant(s): This study is being conducted by Mohammed Sani Saadatu School of Post Basic Public Health Nursing Kaduna Nigeria

Sponsor(s) of research: Self

Purpose(s) of research: This study seeks to explore **cultural beliefs and practices of mothers towards neonatal health in Igabi LGA of kaduna state**

Procedure of the research, what shall be required of each participant and approximate total number of participants that would be involved in the research:

The study population will consist of mothers with babies (neonate) aged 0-28 days resident in

Igabi LGA of Kaduna State. A Convenience sampling method will be use to recruit 400mothers into the study. Mothers will be enrolling into the study at the postnatal clinics in the Primary Health Centers of the six selected Wards of Igabi LGA of Kaduna State. Inform consent forms will be explicitly explained and interpreted in Hausa where mothers can not read and understand English before administering the questionnaires. Participants will have the liberty to withdraw from the study any time they so wish. Questionnaires used for the interview will be coded before administering them to respondents in order to minimize the loss of confidentiality.

Expected duration of research and participant(s)' involvement:

The study is expected to cover the period of six months starting from September 2016 – March 2017.

Risk(s): Sensitive questions will be asked which might make mothers feel uncomfortable.

Costs to the participants, if any, of joining the research:

Mothers are not to pay any amount for participating in the study. However, one pampers will be given to each of them as an incentive.

Benefit(s): This study aims at improving household practices in newborn care, and also Improving neonatal survival.

Confidentiality: Information collected will be coded and no name will be recorded in order to protect the identity of the study participant. Individuals who qualify to participate in this study but are not willing to do so will not be affected in any way by their decision.

Voluntariness: Your participation in this research is completely voluntary. Participants who fit the inclusion criteria can **voluntarily** give their consent to participate.