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Socio-economic and Cultural Background of Hospitalised Children in Ilesha

GA OYEDEJI*

Summary

Oyedeji GA. Socio-economic and Cultural Background of Hospitalised Children in Ilesha. *Nigerian Journal of Paediatrics* 1985; **12:111.** The parents or surrogates of 546 consecutive paediatric admissions into the Wesley Guild Hospital, Ilesha, were questioned regarding the socio-economic and cultural backgrounds of the children. The majority of the parents were christian Ijesha Yorubas. Only 68.7% of the patients were in the custody of their two parents living together. Twenty-seven percent of the fathers and 34.6% of the mothers had no formal education. Sixty-five percent of the parents were in the lower social classes (IV and V) and 90% of them were married under traditional law and custom. Half of the moslem fathers and 40.9% of the christian fathers had more than one wife each. The numbers of children per father and per mother were 5.2 and 3.3 respectively. Correction of the various social problems encountered require public enlightenment and health education.

Introduction

THE influence of socio-economic and cultural factors on health and certain diseases has been highlighted in the medical literature.[1-6] The aetiological roles of these disease entities in childhood morbidity and mortality have also been emphasized.[6-8] Details of the nature of these socio-economic and cultural factors however, need to be reviewed periodically, especially in the light of continuous admixture of foreign influence into developing countries. Thus, the epidemiology of some of these diseases may be modified by factors of social change. For example, when a predominantly farming population changes to other jobs, a substantial proportion of their income will be spent on food which was previously cost-free and malnutrition is a possible result of such a social change.

This paper is an attempt to define the prevailing socio-economic and cultural factors among families of hospitalised children in Ilesha.

Subjects and Methods

The study was conducted in the Wesley Guild Hospital, Ilesha, which is the main health institution that provides specialist as well as general paediatric services to the semi-urban Ijesha community of western Nigeria (estimated population, over half a million) as well as the

University of Ife, Ile-Ife

Department of Paediatrics & Child Health

*Senior Lecturer

surrounding villages and towns within about 40 kilometre radius.

A questionnaire was administered on the mothers or surrogates of all consecutive admissions into the children's wards of the hospital, during the three-month period, September 1—November 30, 1982. The information sought included details of the education, occupation, marital status, residential address and religion of the parents or custodians, as well as the family size. The age, sex and birth order as well as the admission diagnosis of each child, were also ascertained.

Socio-economic index scores were awarded to each child, based on the occupations and educational attainment of the parents or their substitutes. For occupation, class I was allocated to senior public servants, professionals, managers, large scale traders, businessmen and contractors; class 2 to intermediate grade public servants and senior school teachers; class 3 to junior school teachers, drivers and artisans; class 4 to petty traders, labourers, messengers and similar grades and class 5 to the unemployed, full-time housewives, students and subsistence farmers.

For the educational scale, class 1 was awarded to University graduates or equivalents; class 2 to school certificate (Ordinary Level GCE) holders who also had teaching or other professional training; class 3 to school certificate or grade II teachers' certificate holders or equivalents; class 4 to those who had modern three and primary six certificates and 5 to those who could either just read and write or were illiterate.

The mean of four scores (two for the father and two for the mother) to the nearest whole number, was the social class assigned to the child. For example, a father who was a university lecturer would score 1 for his occupation and 1 for his education as a graduate. If his wife was a businesswoman with the school certificate level of education, she would score 1 for her occupation and 3 for her education. The total of these four scores would be 6 with an average of 1.5; when taken to the nearest whole, the number was 2. Thus, the social class assigned to this child was II.

Statistical analysis of data obtained was carried out by means of the X^2 test.

Results

There were 576 paediatric admissions during the three-month period. Thirty of the children were excluded from the study because of incomplete data. The results presented are on the remaining 546 children who constituted 20.6% of a total of 1,654 children admitted into the children's wards during the year, 1982.

Characteristics of the children and diagnosis

Of the 546 patients, 312 (57.1%) were males and 234 (42.9%), females. The ages ranged from a few hours to 14 years. One hundred and eighty seven (34.2%) were aged less than 1 month; 107 (19.6%), 1-12 months; 103 (18.9%) 13-24 months; 50 (9.2%) 25-36 months; 23 (4.2%) 37-48 months; 16 (2.9%) 49-60 months and 60 (10.9%) were aged 61 months and over. Table 1 shows the main diagnoses on admission. There were many instances of multiple diagnoses, thus resulting in a total of 767 diagnoses.

Demographic and personal characteristics of the parents/surrogates

Five hundred (91.6%) of the fathers or surrogates were of Yoruba ethnic origin and 46 (8.4%) were non-Yorubas, mainly from the eastern and mid-western states of Nigeria. Two hundred and fifty-two (46.2%) of the 546 fathers/surrogates were Ilesha indigenes whilst 124 (22.%) hailed from towns around Ilesha. The rest were from other towns. Both parents were christians in 435 (79.7%) cases and moslems in 94 (17.2%) cases. Nine fathers were moslems and their wives christians,whilst seven fathers were christians and their wives moslems. One father and one mother respectively, belonged to other religions.

One hundred and seventy (31.1%) of the parents were not living together. The two parents living together, were the custodians in 375 (68.7%)

TABLE I

Main Admission Diagnoses in 546 Children*

Diagnosis	*No of Cases*	*% of Total*
Neonatal jaundice	107	19.6
Pneumonia	83	15.2
Gastroenteritis	78	14.3
Febrile convulsion	46	8.4
Malaria	43	7.9
Anaemia	40	7.3
Neonatal sepsis	39	7.1
Prematurity	32	5.9
Protein-energy malnutrition	30	5.5
Measles	29	5.3
Heart failure	29	5.3
Wheezy bronchitis	27	4.9
Sickle-cell crisis	14	2.6
Septicaemia	14	2.6
Birth asphyxia	11	2.0
Others	145	26.6

* There were many instances of multiple diagnoses

TABLE II

Occupations of Parents/Surrogates of 546 Children

Occupation	*No of Fathers/ Surrogates*	*% of Total*	*No of Mothers/ Surrogates*	*% of Total*
Artisans	133	24.3	107	19.6
Farmers	121	22.2	31	5.7
Drivers	78	14.3	0	0
Large-scale traders, businessmen and contractors	55	10.1	30	5.5
Intermediate grade public servants	45	8.2	16	2.9
Teachers	36	6.6	47	8.6
Senior grade public servants, professionals and managers	26	4.8	2	0.4
Labourers, messengers and similar grades	24	4.4	10	1.8
Students	15	2.7	33	6.1
Petty traders	8	1.5	200	36.6
Unemployed/full-time housewives	5	0.9	70	12.8
Total	546	100.0	546	100.0

cases whilst the mothers living apart from the fathers were custodians in 107 (19.6) cases and the fathers in 9 (1.6%) cases. The grandparents were the custodians in 51 (9.3%) cases and the aunts of the children, in 4 cases.

The occupations of parents or their substitutes are shown in Table II. The petty traders sold assorted items in small quantities and belonged to the low income group compared with large scale traders who were shop owners and came within the middle to high income group bracket. Artisans (carpenters, tailors etc) were private or public-employed workers in the low income group. Eighty-four (78.5%) of the 107 female artisans were dress makers. Of the 36 male and 47 female teachers, 25 and 31 respectively, were primary school teachers, whilst the remainder were high school teachers. The farmers were mostly peasants engaged in subsistence farming.

Table III shows the educational levels attained by the parents or their substitutes. One hundred and seventy-seven(32.4%) fathers and 234 (42.8%) mothers had no formal education, whilst only 112 (20.5%) of the fathers and 77 (14.1%) of the mothers had secondary and post-secondary education. Although the fathers were generally better educated than their wives, 28 illiterate fathers married wives who had some primary school education.

TABLE III

Educational Levels attained by the Parents/Surrogates of 546 Children

Level	*No of Fathers/ Surrogates*	*% of Total*	*No of Mothers/ Surrogates*	*% of Total*
No formal education	177	32.4	234	42.8
Primary six (first) school leaving certificate	197	36.1	186	34.1
Modern three	60	11.0	49	9.0
Ordinary level GCE West African School Certificate, grade 2 teachers and equivalents	54	9.9	54	9.9
School Certificate (ordinary level GCE) plus teaching or other professional training	29	5.3	21	3.8
University	29	5.3	2	0.4
Total	546	100.0	546	100.0

Thirty six (6.6%) of the parents/surrogates were classified as being in social class I, 49 (9%) in II, 106 (19.4%) in III, 176 (32.2%) in IV and 179 (32.8%) in V. Thus, 191 were in social classes I - III and 355 in IV and V.

Four hundred and eighty-two parents were married (90% under traditional law and custom) whilst 64 (11.7%) were not. Two hundred and forty-nine (51.7%) of the 482 marriages were monogamous and 233 (48.3%) polygamous; the number of wives in the latter ranged from 2 to 11. One hundred and eighty-one (40.9%) of the 442 fathers who were christians had more than one wife each, compared with 52 (50.5%) who had polygamous marriages, out of the 103 fathers who were moslems.

The number of children born to each father ranged from 1 to 29 (mean, 5.23). Of these, the number born to a father by the patients' mother ranged from 1-9 (mean, 3.32).

Diagnosis and Social class

Table IV shows the frequency of the top ten diagnoses in relation to the social classes of the parents. Neonatal jaundice, followed by pneumonia, gastro-enteritis, febrile convulsion and malaria, was the commonest condition in the series. A significantly higher proportion of children with the above diseases except neonatal jaundice, came from the lower social classes (IV and V) when compared with those from the higher social classes (I-III). Similarly, the proportion of children from social classes IV and V with protein-energy malnutrition or measles, was significantly higher than those from social classes I-III.

Social problems

The social problems identified are shown in Table V. Eighty-nine (16.3%) of 546 mothers were divorced from their previous husbands and were now married to the patients' fathers. Of 64 unmarried mothers, 32 (50%) were girls still attending schools while 17 (26.6%) were living with the fathers of the patients. Three of the 32 school girls were aged 14 years, while the rest were aged between 15 and 19 years. Two mothers were mentally retarded, 2 had died and another 2 had absconded and abandoned their infants. Three fathers had children from extra-marital relations and 6 of the patients were children from the mothers' previous marriages.

Discussion

Planners and providers of health services for children should take cognisance of the socio-economic and cultural factors prevailing in their areas of operation because of the recognised effects[3] of these factors on children's health. For example, it has been shown that children from

TABLE IV

Frequency of Main Diagnoses according to Parental Social Classes

Diagnosis	*Social Class**					*Total*	*P***
	I	II	III	IV	V		
Neonatal jaundice	1	9	23	32	42	107	>0.5
Pneumonia	0	2	7	30	44	83	<0.001
Gastroenteritis	0	3	11	22	42	78	<0.001
Febrile convulsion	0	1	2	20	23	46	<0.001
Malaria	0	1	5	18	19	43	<0.01
Anaemia	0	2	7	17	14	40	>0.05
Neonatal sepsis	0	5	3	14	17	39	<0.05
Prematurity	1	2	5	10	14	32	>0.5
Protein energy malnutrition	0	1	4	12	13	30	<0.05
Measles	0	0	5	10	14	29	<0.05

* Total no of subjects from higher social classes (I–III) = 191

* Total no of subjects from lower social classes (IV & V) = 355

** p = level of significance of differences between higher social classes (I—III) and lower social classes (IV&V)

families in the higher socio-economic classes (SEC) possess more health knowledge than those from lower ones,[1] thus implying that the former are likely to stay healthier than the latter. Furthermore, diseases such as pneumonia, gastroenteritis, measles and protein-energy malnutrition that were encountered in the present study, are known to be common killers in socio-economically underdeveloped countries.[4 6–8] As shown in the present study, the children who often fall victims to these diseases are mainly from families in the lower SEC. The main reasons for the higher incidence of these diseases among the lower SEC include parental poverty, lack of good formal education as well as of social amenities.

About one-fifth of the children in the present study lived with their mothers, while 10% lived with other relations who were mostly the grandparents. Yet, it has been shown that children who live with grandparents are prone to malnutrition.[9] Many of these grandparents are not only in need of care themselves, but they also hold old-fashioned and superstitious views on child-rearing.[9 10]

Polygamy was practised in 48.3% of all marriages in the present study. Although it is Islam that permits polygamy, there was no significant difference between the proportion of polygamous marriages involving christians compared with those that involved moslems. Thus, culture rather

TABLE V

Social Problems identified in 346 Children

Problem	*No of Patients*	*% of Total*
Mothers are divorcees; now remarried to patients' fathers	89	16.3
Unmarried mothers	64	11.7
Parents separated	23	4.2
Divorced parents	14	2.6
Mothers divorced more than once before	8	1.5
Fathers dead	8	1.5
Mothers remarried to dead fathers' relations	6	1.1
Total	212	38.8

than religion may be the determinant factor of family structure. While polygamy together with the extended family system may provide some social security and also take care of some of the problems of illegitimacy, its effects on the growth and development of children may however, be unhealthy. For example, the greater the number of children, the less time the father has for an individual child. Furthermore, more wives mean more children, in-laws and social responsibilities for the man. Often, the atmosphere in polygamous homes is that of jealousy, suspicion and strife among the children. Even when a polygamous father has the resources to cater for the needs of his children, the unhealthy rivalry among his wives may hinder him. In the past, most Nigerian men were farmers and polygamy was an asset since it enlarged the labour force available to the man and so determined the size of his farm and his importance in the society. In the present study, few of the parents were farmers while most were poor.

Eighty-nine (16.3%) of the mothers in the present study were divorcees who had remarried. Eighty-one of these had children for their previous husbands, and it was observed that the care of such children was usually unsatisfactory. This was because some were often abandoned by their own fathers in their mothers' new matrimonial homes while others were rejected by their mothers' new husbands and were not well integrated into their new families.

Thirty-two (50%) of the unmarried mothers in the present study were schoolgirls and victims of accidental pregnancies. In a previous study by the author, it was found that significantly greater proportions of children born by school-age mothers suffered from gastroenteritis and protein-energy malnutrition than those born by older mothers.[13] In addition, other evidences of defective parentage were found in the school-age mothers. For example, significant numbers of them failed to get their babies immunised or bring them back for follow-up clinic appointments.

The present study, being hospital-based and conducted over only three months, has limitations; it nevertheless, indicates the socio-economic factors which appear to be associated with diseases in the community.

The factors identified in the present limited study are to a large extent, preventable. For instance, health education, including contraceptive techniques and appropriate guidance and counselling on marriage, are likely to reduce the number of school-age mothers. Appropriate guidance and counselling on marriage may reduce the incidence of marital disharmony, divorce and separation. Adequate education together with public enlightenment and discussion on the roles and responsibilities of parents may encourage some men to limit the number of their wives and children. Homes, schools, religious bodies and community leaders have important roles to play in achieving these objectives. The government on its part, also needs to improve the socio-economic conditions of the citizens and take appropriate steps to ensure the training of adequate numbers

of social workers who have a vital role to play in minimising the adverse effects of various socio-economic factors on the health of our children.

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