

## Traditional Teachings and Practices for Child Health in Ghana

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### Abstract

Majority of rural denizens have limited access to modern medical as well as other health facilities. In the absence of adequate, readily accessible modern medical facilities, traditional teachings and practices concerning child health have proved to be a useful substitute and/or complement. Using qualitative data from selected communities in Central, Greater Accra and Ashanti Regions of Ghana, the paper examined traditional teachings and practices for child health. The results indicated a high level of utilization of both modern and traditional medical services and practices for child illnesses which feign complementary. Information gathered through in-depth interviews, focus group discussions, narratives and conversations found that each society hands down mores from generation to generation by teaching certain attitudes, practices, beliefs, legends, customs, habits and prodigy. The study advanced that there are traditional beliefs and practices in all areas of life, including health in general and child health in parts. These practices include breastfeeding, massaging and postpartum sexual abstinence, for the health of the suckling infant and toddler, while socialization of good hygiene and nutrition practice is initiated and encouraged for the growing child. These reflect the values and beliefs held by members of the community for periods often spanning generations. Such practices recognize the critical importance of children's right to health and survival, an issue at the heart of the UN charter on the right of the child. These results have implications for health policy and planning regarding the incorporation of traditional health teachings and practices into the child health aspect of Primary Health Care programmes and the UN convention on the rights of the child.

**Keywords:** traditional teachings and practices, child health, breastfeeding, postpartum sexual abstinence, Ghana.

### 1.0 Introduction

At the United Nations General Assembly in 2000, world leaders through the Millennium Declaration resolved to improve the health of children by reducing by two-thirds the mortality among children under five by the year 2015. Recent evidence highlights global and national concern and resolution to improve the health of children (UNICEF, 2000; Ghana Statistical Service, 2008, 2003; Ghana Government, 2006). This was to be achieved by establishing and supporting systematic outreach activities to promote access to and utilization of basic health services to vulnerable groups; implementation of national strategies of immunization and nutrition and continued hygiene and sanitation promotion, including malaria prevention and de-worming, and the construction or rehabilitation of water and sanitation facilities in communities and primary schools.

However, about 49% of the world's population dwell in the rural areas and these people have limited access to modern medical as well as other health facilities (Population Reference Bureau, 2012; Senah, 2008; IFAD, 2001). Such population, most often, have restricted themselves to the use of traditional medicines, traditional teachings and practices for health care, including that of children (Gyasi et al, 2011). These practices and teachings are handed down by the elders and ancestors from generation to generation and a critical area of this holistic traditional education is the health of the child. The rapid rates of modernization, urbanization, and social change experienced in African countries make it difficult to determine how often traditional teachings and practices for child health are still used (Robey, 1992). Notwithstanding, in the absence of modern medical facilities, traditional teachings and practices concerning child health have proved to be a useful substitute and/or complement. Evidence indicates the importance and concern for child health in social, cultural, norms, values and related issues (Senah, 2008; Odotei 1989; Field, 1989).

Culture is considered as a dynamic determinant of health and ill-health. Birth and child care related beliefs and practices are also regarded as cultural elements which are potent to affect health (Aksayan and Hayran, 1992). There are various traditional child care practices in different cultures. In India, breastfeeding is believed to be

good and God's gift and cultural practices surround its initiation (Beser et al, 2010). Abrahams et al (2002) studied indigenous healing practices and self-medication among pregnant women in Cape Town, South Africa and observed that majority of Xhosa speaking women follow indigenous health practices for both themselves and their babies because of the need to strengthen the womb against witchcraft or sorcery, to prevent childhood illnesses, and to treat symptoms they perceive that biomedical services would not be able to treat (Peltzer et al, 2009). In a study of traditional practices and other socio-cultural factors affecting the health of children in Saudi Arabia, Abdullah (1993) observed that although medical services in the study prefecture have tremendously improved overtime, and health centres are easily accessible to most people, traditional practices of various categories are widely embraced, particularly those that boost child's health. This move is influenced by grandparents, religious beliefs and failure of modern medicine to find an answer to some chronic disorders. Tulloch (1999) has also reiterated that even though health has improved globally in the past two decades with declining childhood morbidity and mortality across the globe by nearly a third, this progress has blatantly been lopsided leading to health inequities and inequalities (Buor, 2008; Gwatkin et al, 1999). Infectious diseases, malnutrition, and poor maternal and child health continue to account for about half of the global disease burden in the developing world (Accorsi et al, 2003; World Health Organization, 1999). Unacceptably high percentage of this burden is related to avoidable and or preventable causes of childhood death (Accorsi et al, 2003). In this regard, reliance on traditional health beliefs and practices is widespread, and traditional healers may often be the first point of health-care contact. Practitioners share the common culture, beliefs and values as their patients; and play a potentially valuable role in the delivery of primary health care (Kubukeli, 1999; Accorsi et al, 2003). In Turkey, Beser et al (2010) found in traditional child care practices among mothers with infants less than 1 year old that Turkish mothers had traditional child care practices pertinent to bathing and cutting nails of babies for the first time, swaddling as well as the removal of the umbilical cord.

Some health care providers remain suspicious of traditional remedies and practices though, most agree that traditional healers can play an important complementary role in health care provision (Bodeker et al, 2006; Baggaley et al, 1996; Burnett et al, 1999; Bulterys et al, 2002) particularly for children. Use of traditional medicines on infants and consultation with traditional healers seem to be common in developing countries (Peltzer et al, 2009). In Ghana, limited information on traditional teachings and practices related to child health is available. This however is perceived to be the crux of child health, growth and development particularly in rural settings. The current study was therefore designed to examine the pertinent traditional teachings and practices on child health in the Ashanti, Central and Greater Accra Regions of Ghana. Specifically, the study sought to address the following: 1. The basic elements of traditional health practices for infant and child health; 2. Main health practices for three stages of childhood – the infant, toddler and young child; 3. Evidence of the pluralistic utilization of these traditional health practices and modern services for infant and child health.

### **Our children, Our Heritage**

1. **“Agoo!!!”** - Attention please! “Be Fruitful, Multiply, Replenish the earth, subdue it”.
2. **“Tswa! Tswa! Omanyaba!”** – Good fortune must be our lot!
3. **“Asukonomaa”** – Suckling infant,
4. **“Abofra”** – The Toddler, With and among the animals,
5. **“Akoa daa”** – The Young Child, To serve all, sent by all,
6. **“Tswa! Tswa! Omanyaba!”** – Good fortune must be our lot!

## **2.0 Methods**

### *2.1 The study setting*

The study areas were selected communities in the Central (Frami, Brenu Akyinim; Abuesi; Komfoeku – Denkyira/Fanti/Ahanta); Greater Accra (Ngleshi Amanfro; Gidan Tuba -Tubaman); Ashanti (Adugyama, Esereso) regions of Ghana. These areas were selected to provide comparability, diversity in geographical, ecological, ethnic, linguistic and other socio-cultural differences (economic, religious, culture and social organizations, patrilineal and matrilineal groups). Besides, the selected regions depict prefectures where traditional healing, teachings and practices are relatively common and form the crux of livelihood of the people and therefore warrant inclusion in the current research.

### *2.2 Study design, participants, sampling and data collection*

Social survey and ethnographic methods were used to collect both qualitative data, through a variety of methods. Data was collected from 300 respondents. These were 100 adolescent mothers with two or three generation of mothers in the family - The adolescent mother; her mother, grandmother, where possible great grandmother. The adolescent were married and single aged 15-24 who have experienced at least one pregnancy and or childbirth (Sub divided into 15-19 and 20-24). The grandmothers and elders provided important source of traditional knowledge, most of which have been given orally and not documented. Additional information was obtained from Traditional Birth Attendants, herbalists and healers.

Snowball method was used to select adolescent mothers with two to three generation of mothers, that is, the adolescent mother, her mother, her grandmother and great grandmother, if the latter was alive. A standard quantitative structured questionnaire was used to collect demographic, social, economic and reproductive health data on the adolescent. Qualitative techniques including focus group discussions and in-depth interviews with mothers, traditional healers, traditional birth attendants on one hand and conversation, narratives and participants observation with mothers, grandmothers and elderly women on the other hand were considered during data collection.

Study participants were interviewed in three different dialects, viz. Asante Twi, Fante Twi and Ga from the three study region. Prior to the interview exercise, an informed consent was taken from each respondent. In this perspective, the rationale behind the research was explicated and strict confidentiality of the information obtained from participants was assured. Responses were audio-taped and detailed notes were also taken to reinforce the process. The study protocol was approved by the Committee on Human Sciences Research and Publication, School of Medical Sciences, Kwame Nkrumah University of Science and Technology, Kumasi. On average, each interview lasted about 40 minutes.

### 2.3 Data analysis

The study wholly utilised a qualitative approach. The transcripts and notes derived from the interviews, focus group discussions and narratives were translated from the local dialect (i.e. Asante Twi, Fante Twi and Ga) to English. The transcripts were then analysed using content analysis by means of a set approach according to guidelines given by Krueger (1988) and by Stewart and Shamdasani (1990). The transcripts and notes were initially reordered to the topics addressed by the discussion. Then, various repeated concerns and issues were discussed at length by the participants, and relevant parts from each interview and notes were ordered by these issues, using direct quotation approach (Peltzer and Mngqundaniso, 2008).

### 3.0 Results

Results presented are mainly from in-depth interviews, focus group discussions, conversation and narrative from mothers and grandmothers. The results indicated high levels of utilization of both modern and traditional health services and practices for child illnesses among others. In most cases, traditional and modern health practices were complementary, as pointed out by one of the grandmothers:

*“During pregnancy, the mothers are encouraged to attend clinic. However, mothers are also given traditional medicine for themselves and the unborn baby”.*

*(65 years Fanti Grandmother).*

Conversations with and narratives from the elders and grandmothers indicated that each society hands down traditions from generation to generation by teaching certain attitudes, practices, beliefs, legends, customs, and habits. There are seven basic goals of traditional teachings. These include teachings, learning, instructions and socialization processes based on and suited for the prevailing mode of life of the indigenous group. There are traditional beliefs and practices in all areas of life, including health in general and child health in particular. Such practices include breastfeeding, massaging and post partum sexual abstinence, reflect the values and beliefs held by members of the community for periods often spanning generations. The approach is holistic, comprehensive, spiritual, physical and communal, all processes aimed at developing all aspects of child health.

This is illustrated in the text of the libation during the out-dooring and naming ceremony of the child among the Ga ethnic group, during which all participants, including the child are addressed. Paramount in this ceremony is the spiritual and physical wellbeing of the new member of the community. Implicit here is an indication that children have rights to health, a right which should not only be the concern but must be protected by all members of the community. The basic elements of the ceremony therefore have a special relevance to the right of the child to health. Such rights include access to quality health care and wellbeing as mandated by the United Nations Convention on the Rights of the Child (CRC), a non-negotiable standard and obligations built on varied legal systems and cultural traditions.

Teachings and practices on health emphasized the following: nutrition, breastfeeding and postpartum sexual abstinence; use of water, cold, warm, hot; massage using oils such as shea-butter, palm-kernel oil; beads, to monitor growth and diarrhea; a medicinal brass bowl containing such items as metals, charcoal, clay, sponge; plants, roots, barks, herbs, mixtures, etc. All these were expected but not limited to cure, prevent and promote hygiene, good health, exercise or survival skills of the child and mother. The older women; grandmothers; traditional birth attendants; healers make reference to health in general and child health specifically in direct and indirect ways. Several activities take place to ensure the child will be healthy with special emphasis on maternal and child health, stressing breastfeeding and post partum sexual abstinence. Uncleanliness and hygiene, especially personal hygiene of the mother, etiology of diseases-diarrhea, malnutrition (“Kwashiokor”) associated with early sexual relations, contaminated breast milk of mothers are some of the oral teachings by the older women. This important role of the older women is expressed in the words of an Ashanti older woman:

*"It is important that the older women look after the baby and also the mother. They provide post natal care, assist with cleaning the baby with herbal solution, massage etc" (60 years Ashanti woman).*

### 3.1 The Suckling Infant "Osukonoma"

At this early stage there is great emphasis on the health, wellbeing and nutrition for both the infant and the mother. Breastfeeding for the baby is mandatory and post-partum sexual abstinence is emphasized for the mother. Water is used--cold, warm or hot--to maintain general cleanliness. There is extensive massage for both baby and mother, using various kinds of oils which include shea-butter, palm kernel oil and others. Beads of various colors and sizes are tied round the wrist, waist and ankles to monitor the growth and also the nature of infant diarrhea. In a brass bowl kept by the older women are items such as herbs, mixtures, white clay, soft sponge, charcoal, etc. All these are expected to address and prevent any health problem of the infant and the mother.

### 3.2 The Toddler "Abofra"; crawling, picking, tasting all

The breastfeeding and massage for the suckling infant is continued during this second stage when the child is crawling, picking and tasting everything. In addition, as weaning foods are introduced to the toddler, there is emphasis on practices that prevent health problems associated with environmental hygiene and spiritually connoted ailments. These include the use of herbs, plants, metals as gold, silver, copper, brass, etc, to prevent environmentally related problems like colds, cough, other respiratory and such ailments purported to be of spiritual undertones. Under these circumstances, the approaches have invariably been preventive rather than curative, using traditional and culturally recognized medicinal herbs, plants and metals.

### 3.3 The Young Child "Akoa-daa"; sent by all, slave for all

The emphasis at this stage is on socialization on health and other practices. The process is orally based, by all, especially older women and grandmothers. The process at this stage includes practices by which all aspect of the health of the child is developed, direct physical health as well as socialization processes teaching the child behaviours which promote good health, hygiene, nutrition, exercise, games, survival skills, moral and social values. In the traditional setup therefore, even though the child has only one biological mother, the promotion of good health is a communal responsibility, with many educators and providers. Significantly, in as much as traditional health practices are to complement the orthodox or modern practices, care givers as in parent and kinsmen have the responsibility to promote the health and wellbeing and are expected not to indulge in any practice that has any potential adverse health effect on the child.

## 4.0 Discussion

The convention on the rights of the child was set out in 54 articles and two Optional Protocols in relations to the United Nations treaties on human rights in September 1989. The purpose of this convention was to ensure that the special needs of children are addressed by governments and society, in addition to the fundamental human right (UNICEF, 2000)

Article 24 states that parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. Parties shall also strive to ensure that no child is deprived of his or her right of access to such health care services. Furthermore sub section 2c states parties shall pursue full implementation of this right and, in particular, shall take appropriate measures to combat disease and malnutrition among others, within the framework of primary health care. Children are at the heart of the United Nations' eight Millennium Development Goals (MDGs) with MDG 4 committed to reducing infant mortality. UNICEF joins governments, other agencies and civil society to achieve these goals by 2015.

The Government of Ghana giving recognition that children are vulnerable and require special protection, appropriate to the age, level of maturity and individual needs, ratified the UN Convention on the Rights of the Child, and was the first country to do so in February 1990 after the Convention came into force in September 1989 (Ghana Statistical Service, 2008). Ghana, to protect her children against harmful traditional practices included a whole chapter on the rights of a child in the 1992 Constitution (Ghana Government, 2006). As part of effort to ensure the right of children, the government created a Ministry Of Women And Children Affairs to see to the enforcement of the right of children in the country. There is also the woman and juvenile division of the police service of Ghana to also ensure the enforcement of child's right and deal with issues of child abuse. The ministry in it effort has also outlined some policies which are geared towards child's right and development. An example is the ratification of the ILO Convention 182, in 2000, that prohibits worst forms of child labor (MOWAC, 2006). Ghana before the adoption of the UN Convention on the Rights of the Child (CRC) established in 1989, the Ghana National Commission on Children to see to the general welfare and development of children and co-ordinate all essential services for children in the country, with the view to promoting the rights of the child.

In addition to these international and national concerns for child health, evidence from the study suggested that traditional and socio-cultural practices and teachings that ensured personal hygiene, reproductive health and

child's rights to health have existed in communities in the Ashanti, Central and Greater Accra regions of Ghana. Unfortunately, the elements of these teachings have not been acknowledged in government programs, almost twenty years after Ghana ratified the UN Convention. The issues of traditional and modern health practices and programmes and approaches to child's right to health (survival) and access to health care becomes juxtaposed as a holistic effort at ensuring child health and ultimately survival. This underscores the study's conception of health. From this perspective, the traditional teachings, learning, instructions and socialization processes becomes a critical integrated part of the modern conventional conception of healthcare, specifically the right of the child to health.

### 5.0 Conclusion

The results from this study have implications for health policy and planning regarding the incorporation of traditional health teachings and practices into programs committed to children's rights to health. The starting point for child health policy should be the traditional system with a focus on the basic good, positive elements. The old ladies are the custodian of traditional knowledge. The oral traditions have no written documentation. The symbol of "Sankofa" should guide and provide a renaissance for the maintenance of treasured positive traditional health values, grown out of our roots and not grafted, that promote child health. It is recommended that more time should be devoted to teaching parents and everyone directly or indirectly associated with the upbringing of children including nurses, medical students and junior doctors.

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