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Are the Mothers of Hospitalized Socially Disadvantaged Children worse Care Givers than those of Non-disadvantaged Children?

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Summary

Oyedeji GA, Ajibola AJ, Oyedeji AO. Are the Mothers of Hospitalized Socially Disadvantaged Children worse Care Givers than those of Non-disadvantaged Children? *Nigerian Journal of Paediatrics* **2002; 29:113.** The level of general hygiene, duration of breastfeeding and number of doses of scheduled immunizations received by 207 socially disadvantaged and 237 non-disadvantaged controls, mostly under five-year old children, admitted to the Wesley Guild Hospital, Ilesa, over a six-month period, were studied through physical inspection and administration of questionnaire. Compared with controls, higher percentages of disadvantaged children received none or incomplete doses of scheduled vaccinations ($p<0.001$), were breastfed for a total of less than 18 months ($p<0.05$) and were kept below average standard of hygiene ($p<0.001$). The findings suggest that there is need to further define the factors of social disadvantage prevalent in our communities and their effects on the health of children in order to effectively reduce the incidence and ill effects of such social disadvantages.

Key words: Mothers, Social, Disadvantage, Care givers

Introduction

SOCIAL disadvantage is variously defined in different socio-economic circumstances. In the British National Child Development study, children from families with poor socio-economic status, poor housing, one parent or many children were included and made up to six percent of the total children surveyed.[1,2] There is scanty literature on social disadvantage and its effect on child health in developing countries. This may be due to the dominant poor socio–economic conditions coupled with other more urgent health problems demanding attention in such countries. Besides, there are children who are members of families in which the parents are young, mentally retarded, or poorly educated, or who are involved in crises situations which may include dismemberment through death, divorce or separation and demoralization through unemployment, illegitimacy, deviant or antisocial behaviour; children from such background should also be considered socially disadvantaged.

The present communication is part of a larger study to examine the influence of social disadvantage on the health of hospitalized children. An attempt was made to identify, by history, those among children hospitalized for all kinds of reasons who may be socially disadvantaged and to compare the quality of parenting they have already received as well as the physical status of their general hygiene in hospital with those of non-disadvantaged controls. Wesley Guild Hospital, Ilesa, where this study was conducted, is the only public

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hospital providing general and specialist care to the Ijesha population of south-western Nigeria. It receives patients from towns and villages spread over a 40 kilometre radius around its semi-urban location.

Patients and Methods

Socio-demographic, child care and other details were obtained by means of a semi- structured questionnaire from the parents or surrogates accompanying 439 children admitted through the children's emergency and out-patient units into the main and isolation children's wards of the Wesley Guild Hospital, Ilesa, between January and June 1998. The children studied were those, out of a total of 788 admissions into the two wards during the study period, in whom the essential details of the study could be completed before their discharge or death. The wards had a rapid turnover rate and the questionnaire was completed as soon after admission as possible, usually within 24 to 48 hours.

An assessment of the standard of care and hygiene of each child was made by noting the state of his or her clothes, skin, hair, nails, teeth, and the materials brought from home for his or her care. The result of the assessment was entered into the study proforma as average, above or below average. To ensure consistency and reduce errors, all the children were studied by two senior residents and one consultant paediatrician, all of whom were conversant with the characteristics of the families and children in the area. The families were allocated into social classes using a combined score derived from the occupation and educational attainments of both parents as previously described.[3]

Children considered to be socially disadvantaged were those :

(a) Born out of wedlock.
(b) Born to unemployed parents, young, illiterate or poorly educated mothers.
(c) Being brought up in polygamous families.
(d) Being brought up by divorced parents.
(e) Being brought up in one-parent families and/or living away from the two parents for such reasons as marital discord, death, desertion or divorce.
(f) Being brought up in displaced families e.g., as a result of communal disturbance.

The results were analysed and, using the chi-square test, the data on disadvantaged children were compared with those of the non-disadvantaged, used as controls.

Results

The Study Population

Seven hundred and eighty eight children were admitted into the two wards during the period of study. Of these, 439 (55.7 percent) were studied – 262 boys and 177 girls with a male: female ratio of 1.5: 1. Of the 439 studied, 207 (47.2 percent) were socially disadvantaged – 127 boys and 80 girls, a male: female ratio of 1.6:1 while 232 (52.8 percent) were non-disadvantaged controls – 135 boys and 97 girls, a male: female ratio of 1.4:1. The age patterns of both the disadvantaged and control groups were similar, as shown in Table I. Thus, 82 percent of the children were aged five years and below.

Education and Occupation of Parents

The educational attainments of the parents are shown in Table II. The fathers were generally better educated than the mothers with 242 (59.7 percent) of the fathers obtaining at least, the secondary school leaving certificate or grade 2 teachers' certificate, compared with

Table I

Age Groups of Patients

Age Groups(mons)	*No of Children*			
	Disadvantaged	*Non-disadvantaged*	*Total*	*Percent of Total*
0 to 12	76	90	166	37.8
13 – 24	42	57	99	22.6
25 – 36	17	34	51	11.6
37 – 48	7	17	24	5.5
49 – 60	12	8	20	4.5
61 – 72	6	7	13	3.0
>72	47	19	66	15.0
Total	207	232	439	100.0

Table II

Educational Attainments of Parents of Disadvantaged Children

Levels Attained	*No of Fathers*			*No of Mothers*		
	Disadvantaged No (%)	*Non-disadvantaged No (%)*	*Total*	*Disadvantaged No (%)*	*Non-disadvantaged No (%)*	*Total*
University Bachelor's, Master's and doctorate degrees	20(11.0)	28(12.3)	48	0(0)	6(2.6)	6
Ordinary or advanced level school certificate plus polytechnic, teaching, nursing or other professional qualification	8(4.4)	27(11.8)	35	12(6.2)	33(14.1)	45
Ordinary level secondary school and Grade 2 teacher's certificate	51(28.2)	108(47.5)	159	39(20.1)	100(42.7)	139
Primary six plus uncompleted secondary school education	6(3.3)	27(11.8)	33	36(18.6)	50(21.4)	86
Primary six	49(27.1)	32(14.0)	81	46(23.7)	45(19.2)	91
Below primary six and Illiterate	47(26.0)	6(2.6)	53	61(31.4)	0(0)	61
Total	181(100)	228(100)	409	194(100)	234(100)	428

* This information was not available in respect of 30 fathers and 11 mothers.

190(44.4 percent) of the mothers. Also, parents of the disadvantaged children were less well educated than those of controls with 102(56.4 percent) of 181 fathers of the disadvantaged children obtaining less than the secondary school leaving or grade 2 teachers' certificates compared with 65(28.5 percent) out of 228 fathers of controls. These differences are significant ($\chi^2 = 32.3820$, $p < 0.001$). In the case of the mothers, the differences are even more striking with 143 out of 194 mothers of disadvantaged children attaining less than the secondary school or grade 2 teachers' certificate levels (73.7 percent) compared with 95 out of 232 mothers of non-disadvantaged children (40.6 percent) {$\chi^2 = 47.1117$, $p < 0.001$}. The main occupations of the parents were similar in both groups (Table III).

Custodians of the Children

Out of the 232 non-disadvantaged children, 217 (93.5 percent) lived together with the two parents whilst nine lived with the mothers alone and six with grandparents and other relations. In the case of the 207 disadvantaged children, only 115 (55.6 percent) lived together with the two parents, 47 (22.7 percent) with their mothers living alone, 43 (20.8 percent) with their grandparents and other relatives and two with their fathers living alone. Thus, 44.4 percent of the disadvantaged children were not living together with both parents.

Social Classes

Seven of the families of non-disadvantaged children were in social class I, 29 in II, 113 in III, 72 in IV and 11 in V compared with three in I, 24 in II, 47 in III, 82 in IV and 51 in V for the families of disadvantaged children. Thus, 149 (64.2 percent) of the 232 families of controls were in the higher social classes I to III

Table III

Main Occupations of Parents of Disadvantaged Children

Main Occupations	No of Fathers			No of Mothers		
	Disadvantaged No (%)	Non-disadvantaged No (%)	Total	Disadvantaged No (%)	Non-disadvantaged No (%)	Total
Trading	18(8.6)	24(10.4)	42	99(47.8)	88(37.9)	187
Artisans eg. carpenters,tailors, hairdressers, auto-mechanics etc	38(18.2)	67(29.1)	105	50(24.2)	87(37.5)	137
Teaching	6(2.9)	20(8.7)	26	11(5.3)	30(12.9)	41
Farming	57(27.3)	25(10.9)	82	27(13.0)	6(2.6)	33
Driving	30(14.4)	33(14.3)	63	0(0)	0(0)	0
Intermediate grade public service	23(11.0)	31(13.5)	54	4(1.9)	10(4.3)	14
Managers,professionals, tertiary institution lecturers, senior public serviceand similar grades	18(8.6)	22(9.6)	40	0(0)	6(2.6)	6
Labourers, messengers and similar grades	12(5.7)	5(2.2)	17	2(1.0)	0(0)	2
Unemployed, full time housewives and students	7(3.3)	3(1.3)	10	14(6.8)	5(2.2)	19
Total	209(100)	230(100)	439	207(100)	232(100)	439

with 83(35.8 percent) in IV to V compared with 74 (35.7 percent) of the families of disadvantaged children in social classes I to III and 133 (64.3 percent) in IV and V. There is a reversal of the percentages in higher and lower social classes in the two categories of subjects.

Social Disadvantages

The various social disadvantages identified are shown in Table IV. The 301 total number exceeds the number of disadvantaged families because of multiple disadvantages occurring in the same families. In the polygamous families, the number of wives per husband ranged from two to 10 with a mean of 2.5; the mothers of the patients were the first wives in 29 families, the second in 77, third in 12, fourth in three, fifth in three and tenth in one. Seventy-five (60 percent) of the 125 polygamous families belonged to the lower social classes IV and V. The fathers or mothers separated by work lived away from the rest of the family on a virtually permanent basis and only visited occasionally.

Early Feeding, Immunization and Hygiene

Table V shows the numbers of respondents in whom information on breastfeeding, cow's milk and cereal feeding within the first few months of life and immunization was available and on whom assessment of hygiene status was made in respect of the disadvantaged and control children. Also, the numbers and percentages of subjects who had the experience as well as their hygiene status are shown. Twenty-three (37.7 percent) of the 61 mothers who were educated below the primary six level defaulted from completing scheduled immunizations for their children. Significant differences were found between the two groups in respect of breastfeeding for up to 18 months, completion of immunizations for age and hygiene status of the children to show poor performance by parents of the disadvantaged children.

Discussion

The childcare practices examined in this study point o an inferior quality of parenting offered by the nothers of disadvantaged children compared with the controls. Various factors of social disadvantage can lead in different ways to this kind of failure. Polygamy, the commonest social disadvantage identified in the present study is more of a cultural than religious factor in Nigeria.[3] It disturbs the environmental security

Table IV

Observed Social Disadvantages in 207 Families

Social Disadvantages	*No of Families*	*Percentage*
Polygamy	125	60.4
Father or mother semi permanently away because of work	22	10.6
Father (6) or mother (15) dead	21	10.1
Parents divorced or separated	26	12.6
Parents unmarried	15	7.2
Mother not educated up to primary six level	61	29.5
Father (7) or mother (21) are divorcees now remarried to other partners	28	13.5
Other disadvantages	3	1.4
Total	301*	

Some patients had more than one social disadvantage.

Table V

Feeding, Immunization and General Hygiene Status of Subjects and Controls

Experience or Status	*Disadvantaged Subjects*		*Non-disadvantaged Controls*			
	No of Responders	*No (%) with Experience or Status*	*No of Responders*	*No (%) with Experience or Status*	χ^2	*P value*
Exclusively breastfed for less than 6 months	194	114 (58.8)	223	112 (50.2)	2.9080	<0.10
Breastfed for up to 18 months or more	194	27 (13.9)	223	49 (21.9)	4.5192	<0.05
Received cow's milk early	207	46 (22.2)	232	43 (18.5)	1.1222	<0.50
Received cereals early	207	59 (28.5)	232	50 (21.6)	2.8123	<0.10
Received none or incomplete doses of scheduled immunization	195	83 (42.6)	226	50 (22.1)	20.2688	<0.001
Has average and above average level of hygiene	201	164 (81.6)	221	204 (92.3)	10.8343	<0.001

provided by families, which is essential for healthy living of children. Thus financial, food, emotional and other forms of family security can be disturbed with the attendant negative impact on the family. Polygamous families are prone to be large. In a previous study in the same area, 48.3 percent of the marriages were polygamous with a mean of 3.3 children per mother.[3] If these figures remain the same, with the mean number of wives per father now being 2.5, the sizes of many families may approach or exceed 10. Such numbers stretch the available family resources and make satisfactory standard of hygiene difficult to achieve. The unhealthy rivalry associated with polygamy can also act indirectly to hinder a mother's child care activities.

Parental divorce and separation constitute over 10 percent of the disadvantages seen in this study. Hartnup has reported that children of divorced parents perform worse socially, behaviourally and academically than those of intact families.[4] Marital discord and divorce plunge the children into lives in one-parent families, as does separation by work or death of one parent or as a result of parents not being married. The children involved in such families suffer from the financial inadequacies and the complications of the broken family life of the custodian parent. This is likely to be the experience of the children in the previous marriages of the remarried divorcee parents in 13.5 percent of the disadvantages seen in this study. It is difficult for separated parents to contribute their expected quota to the finance, attention and supervision needed to ensure correct feeding, prompt immunization and satisfactory standard of hygiene of their children.

Lack of or poor maternal education seen in 29.5 percent of the affected families was the second commonest disadvantage recorded in this study. The positive influence of parental, especially maternal education on child health and survival has been amply demonstrated in other studies.[5-7] This positive effect is partly due to its ability to help mothers procure and use health services to the advantage of their children. Thus, a significantly greater number of disadvantaged compared to control mothers in this study failed to obtain or complete scheduled immunization for their children. Educated mothers in rural Bengal have been shown to use more appropriate measures to ensure the health of their children than their non-educated counterparts,[8] just as inadequate immunization has been linked with lack of maternal education in Nigeria.[9] Moreover, education is both a confounding factor to and a major determinant of social class. Saxenna, Majeed and Jones have shown that general practice childhood consultation rates for social classes IV and V were higher for illnesses, and lower for preventive services, than for social classes I to III.[10] The poore health of lower, compared with higher social clas subjects has been blamed on the failure of the forme to make demands proportionate to their greater need on the services and their receipt of less of others.[11]

Since the effects of inadequate immunization, fault feeding and poor hygiene on child health and surviv can be deleterious, the problem of social disadvantag should be realistically addressed. Further studies ar required to provide data on various aspects of soci disadvantage which will enable health and social worker identify susceptible children and families so that the can be targeted for special attention.

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References

1. Wedge P, Prosser H. Born to Fail? London: Arro Books and National Children's Bureau, 1973: 11-8.
2. Ebrahim GJ. Child Health in a Changing Environmen London: Macmillan, 1982: 146-70.
3. Oyedeji GA. Socio-economic and cultural background o hospitalized children in Ilesa. *Nig J Paediatr* 1985; 1 111–7.
4. Hartnup T. Divorce and marital strife and their effects o children. *Arch Dis Childh* 1996; 75: 1–3.
5. Cleland JG, Van Ginneken JK. Maternal education an child survival in developing countries. The search fo pathways of influence. *Soc Sci Med* 1988; 27: 259–72.
6. Caldwell JG. Education as a factor in mortality declin An examination of Nigerian data. *Pop Studies* 197 33: 17–23.
7. Harrison KA. Antenatal care, formal education and chil bearing. *Br J Obstet Gynaecol* 1985; 92 (Suppl 5): 14–2
8. Goodburn E, Ebrahim GJ, Senapati S. Strategies educate mothers use to ensure the health of their children. *Trop Pediatr* 1990; 36: 255–9.
9. Angyo IA, Lawson JO, Okpeh ES, Pam SD. Socio demographic factors affecting the immunization statu of hospitalized pre–school children. *Nig J Paedia* 1998; 25: 57–63.
10. Saxenna S, Majeed A, Jones M. Socio-economic difference in childhood consultation rates in general practice i England and Wales. *Br Med J* 1999; 318: 642–6.
11. Morris JN. Social inequalities undiminished. *Lancet* 197 i: 87–90.