

## Parents' Knowledge of Childhood Disease and Health-Seeking Options for Children in Central Senatorial District of Cross River State, Nigeria

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### **Abstract**

*Health is a crucial aspect of a fulfilling life, enabling individuals to reach their full potential. However, in many developing nations, ensuring the health of children remains a challenge. This is particularly evident in places like Nigeria, especially in rural and slum communities where childhood diseases are prevalent. These illnesses not only lead to child mortality but also give rise to various other health and social issues, including maternal health, access to quality medical care, and socioeconomic conditions. A significant number of children, especially those under the age of five in third-world countries, are exposed to a range of diseases every year. The difficulty in promptly diagnosing and treating these children with the appropriate medication is often attributed to parental lack of knowledge, deeply entrenched cultural beliefs, and belief systems that are resistant to change. This study focused on understanding the extent of parents' knowledge about childhood diseases and its impact on their choices for seeking healthcare for their children in the Cross River Central Senatorial Districts of Nigeria. To guide the research, specific objectives were formulated, along with research questions. The study employed a cross-sectional survey design, utilising both quantitative (questionnaire) and qualitative (KII and FGD) data collection methods. Among the key findings, it was discovered that there exists a significant relationship between how parents perceive their knowledge of childhood illnesses and their behaviour in seeking healthcare for their children. Based on these findings, the study recommends, among other things, the implementation of comprehensive health education programmes for parents, especially for nursing mothers.*

**Keywords:** Parents' Knowledge, Childhood, Disease, Health, Children, Cross River State

### **Introduction**

Health is a crucial resource for individuals and society as a whole. Without good health, people cannot fully participate in social and economic activities (Sachs, 1999). Recently, there has been increased attention on child health, especially in developing nations, due to the high mortality rate among children compared to developed countries. Parents play a fundamental role in ensuring the well-being of their children, including their custody, protection, education, and overall care. This responsibility is widely regarded as sacred and essential, and it greatly influences a child's development and future.

Among a parent's responsibilities, the health of their child is undeniably significant. How parents' approach and fulfil their parental responsibilities directly impacts a child's health. Positive parental involvement in a child's life can lead to better health outcomes for the child, while neglect can have adverse effects.

Various behaviours and attitudes towards illness by parents pose significant challenges to healthcare providers and the healthcare system in Nigeria. There is often a lack of consensus between Western medicine and traditional medicine. Traditional medicine, which focuses on African traditional remedies (Ojua, Ishor, & Ndom 2013), is not widely promoted or understood in terms of its usage and potential side effects. Many individuals with expertise in diagnosing and treating diseases exist but are not commonly consulted for their proficiency.

Illnesses are often attributed to both natural and supernatural causes, which can influence people's health-seeking behaviour. While many people seek healthcare when they can afford it, reliance on traditional therapies is also common. Accessible and affordable healthcare is essential for good health, but low-income individuals may only seek formal medical care in life-threatening situations. The lack of access to healthcare services reflects poverty and underdevelopment in Cross River Central Senatorial Districts and Cross River State as a whole (World Bank, 2006). Given these factors, this study aims to investigate the challenges faced by vulnerable children who are susceptible to preventable and treatable childhood diseases. These children often suffer premature deaths and disabilities due to certain health-seeking behaviours exhibited by their parents.

### **Statement of the Problem**

Child health issues in Nigeria, as well as in many other Sub-Saharan nations, particularly in rural communities, are a cause for concern. According to the Government Service of Wellbeing (2011), out of 5.9 million births in Nigeria, over 1,000,000 children consistently do not survive to reach their fifth birthday. Shockingly, a quarter of these deaths occur in infants. The Service identified three major causes accounting for three-quarters of infant deaths in Nigeria: birth asphyxia (when a newborn doesn't cry upon delivery), complications from preterm birth, and preventable or treatable infections through modern and traditional medical practices.

The progress made in reducing infant and child mortality in Nigeria is significantly below the sub-Saharan African average of 34%. Studies indicate that many children in Nigeria succumb primarily to diseases such as malaria, diarrhoea, neonatal tetanus, tuberculosis, whooping cough, and bronchopneumonia (Tomkins, 1981; as cited in Ogunjuyigbe, 2004). Both biological and economic factors are influencing child mortality, operating through broader determinants. Therefore, there is an urgent need to intensify efforts to reduce child mortality among the Nigerian population. This imperative has led to the undertaking of a study of this nature.

### **Research Questions**

How does knowledge of childhood diseases, influence the health seeking options of parents with infants?

### **Objectives of the study**

Specifically, the study seeks to

To investigate parental perception of knowledge of illness and its effects on health seeking behavior in the Cross River Central Senatorial District

### **Research hypotheses**

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## **LITERATURE REVIEW**

### **Parental perception of access to health services and health seeking behaviour (availability, distance, financial cost and affordability)**

Poverty and limited access to healthcare services can negatively impact people's health, and vice versa. It is crucial to align the provision of basic healthcare services with established guidelines (as outlined by the WHO in 1997), as cited in Musah and Kayode's work in 2014. This alignment will promote fairness and accessibility and reduce financial burdens on families. However, Musah and Kayode also noted that user fees may hinder access to healthcare services or lead to changes in healthcare-seeking behaviour, particularly affecting those with lower incomes. Essentially, when healthcare becomes too expensive, it becomes inaccessible.

Various factors influence households' and individuals' decisions to seek healthcare for different illnesses. These include knowledge about the illness, attitudes towards seeking treatment, anticipated costs of treatment, perceived severity of the illness, proximity to healthcare facilities, cultural beliefs, prevalence of the illness in the community, and individual characteristics. Health is a significant driver of economic development because productive endeavours require healthy individuals with sound minds (World Bank, 2006).

In the pursuit of healthcare services, individuals often encounter unforeseen costs such as transportation, time off work, and waiting expenses at healthcare facilities. This can significantly impact the extent and adequacy of healthcare utilization. Nwosu, Urama, and Umakpa (2012) emphasised that parents frequently weigh the costs of healthcare services in both traditional and modern providers, influencing their healthcare decisions.

In Nigeria, the responsibility for healthcare provision is shared among federal, state, and local government authorities. They collaborate to deliver healthcare services. Primary healthcare, which aims to bring healthcare services closer to all Nigerians, especially at the community level, falls under the jurisdiction of local government authorities. General hospitals, managed by the state, constitute the secondary healthcare level. Tertiary health institutions, including Teaching Hospitals and Specialist Hospitals, cater to complex cases beyond primary and secondary care and are the responsibility of the government (either State or Federal).

Nigeria, though endowed with abundant material and human resources, faces challenges in providing adequate access to healthcare. Many healthcare facilities struggle to meet the demands of the population. MacFubara, Edon, & Akwagbe (2017) argued that resource allocations across sectors have been uneven, and distinctions between primary, secondary, and tertiary healthcare levels are blurred. Issues like insufficient logistics and technical support for local government areas, compromised drug supplies, and their management, particularly at the primary healthcare level, hinder the utilisation of available healthcare resources in Nigeria. According to Arthui (2012), this situation also influences the healthcare decisions made by parents of young children.

Hanson et al. (2015) conducted a study involving 818,583 individuals from 225,980 families. They found that pregnancy-related mortality was high at 712 deaths per 100,000 live births, with haemorrhage being the leading cause of death. Deaths due to direct causes of maternal and infant mortality were associated with distance, with mortality increasing from 111 per 100,000 live births among those within 5km to 422 deaths per 100,000 live births for those living over 35km from a hospital.

Among parents living within 5km of a hospital, pregnancy-related mortality was 664 deaths per 100,000 live births, even though 72% gave birth in a hospital and 8 percent had a caesarean section. This study concluded that significant distances to hospitals contribute to high levels of direct obstetric mortality. High pregnancy-related mortality among those near a hospital indicates

disparities in care. Efforts to reduce infant mortality focus on improving access to skilled attendance (WHO, 2014) and emergency obstetric care (Paxon et al., 2004).

According to Gabrysch and Campbell (2009), one way to evaluate the impact of skilled care during childbirth on reducing maternal mortality is to assess maternal mortality by proximity to a healthcare facility, as complications should not bias this effect. Parents who live near a healthcare facility are more likely to go there than those who live far away, potentially leading to lower mortality rates. There is strong evidence for the impact of distance care on child health. Mortality among children, infants, and toddlers increases with greater distance from healthcare facilities, although not in all settings (Lohela et al., 2012).

Fisseha et al. (2017) stated that low-income levels of parents affect healthcare utilisation and contribute to the high levels of maternal and infant mortality. They determined from their study that distance to healthcare facilities, mothers' perception of the availability of adequate equipment in the delivery service in their area, having an educated partner, receiving antenatal care, lower birth order, and experiencing any difficulty during childbirth were significant indicators of skilled delivery service utilisation.

## **METHODOLOGY**

### **Research design**

The research design that was adopted for the study was the survey design. This design was chosen amongst others because it enables the researcher used the questionnaire, Key Informant Interviews (KII) and Focus group discussion (FGD), to answer the questions: What? Why? and How? On the subject matter in the study area. It is especially useful in the study to gain familiarity with basic details, generate new ideas and assumptions, and in the process create direction for future research.

### **Area of study**

This research covered “the Central Senatorial District of Cross River State, it is located at the South Eastern fringes of Nigeria, it falls within the south-south geographical zone, a recent structure in Nigeria”. The central senatorial district has six local Government areas, which include, Abi, Boki, Etung, Ikom, Obubra and Yakurr local government areas. It is made up of many tribes, including, Yakurr, Agbo, Agoi, Bahumono ethnic groups are in Yakurr and Abi L.G.A, while the Mbembe are predominantly found in Obubra L.G.A. At the core northern part of the Central District are several sub-dialectical groups among which, are Etung, Olulume, OfutopNkim/Nkum, Abanajam, Nseke and Boki in both Ikom, Etung and Boki LGAs. This district epitomizes the “nation’s linguistic and cultural plurality and it is important to note that in spite of the diversity of dialects, all the indigenous languages in the state have common logistic roots in the Niger-Congo language family, Obubra local government area is one of the councils established during the British colonial rule, its jurisdiction covered parts of the present Biase and Akamkpa as well as Abi, Yakurr and parts of Ogoja and Ikom in Cross River State”.

### **Sample Size Distribution**

Six hundred respondents were drawn from the Senatorial District for the purpose of administration of questionnaires. Since the Senatorial District consisted of Local Government Areas and Political Wards as well as villages, the study adopted a multi-stage sampling technique. At stage one, the six Local Government Areas constituted the first cluster or stratum where the political wards were recognized. In each of the 6 LGAs, the name of the wards was arranged in alphabetical order where 5 wards were systematically selected for inclusion into the study. In all, 30 wards were selected. At stage two, we recognize that each of the wards required representative sample in the study.

### **Sampling Size (Determination)/ Sampling Technique**

The sample of the study was made up of 600 parents residing in the Local Government Area and communities in Cross River Central Senatorial District, to form the representation sample of the study population. Total sample size was 600. The sample comprise parents who have given birth at the time of the study and those who have had parental experiences. These parents who are inhabitants of the study area were from all works of life in the community ranging from “farmers, traders / business people, civil servants, unemployed,” etc.

### **Source of data**

Data in the present work was obtained from “both primary and secondary sources, the Primary source consisted of first-hand information which was obtained from respondents in the process of field work, in this study, the questionnaire, key informant interview (KII) and focus group discussion (FGD) constituted the primary sources of data, the secondary sources of data consisted of review of the work of other scholars, journals, internet materials,” etc.

### **Method of data collection**

The instruments (structured questionnaire FGDs and KIIs) were administered by the researcher to selected respondents in Cross River Central Senatorial District with the help of four research assistants that were trained by the researcher on how to administer the instruments to respondents. Duplicates of the surveys were disseminated to arbitrarily chose respondents in every one of the 41 groups of the review region, respondents who are not proficient were helped by the scientist or the colleague in clarifying any troublesome things, as far as articulation contained in the poll, this technique was taken on to guarantee exact reaction to such things on the survey and to request the collaboration of the respondents. The instruments were recovered around the same time to guarantee 100 percent retrieval.

### **Methods of Data Analysis**

Data analysis was done through hypothesis by hypothesis testing each one at 0.05 level of significance. The researcher first coded the data, and did data entry using Excel 2010 version, which was later transferred into the Statistical Packages for Social Sciences (SPSS) package version 21. The Analysis was first, guided by descriptive statistics and was backed up with verbatim expression from the in-depth interview. Thereafter, the test of hypothesis was also, done using Pearson Product Moment Correlation coefficient *statistical tools*.

### **Key Informant Interview and Focus Group Discussion (FGD)**

This was conducted through structured interview guide based on the objectives of the study. The participants here were parents of both gender and some community leaders. They are the ones living in the study area and have first knowledge about childhood disease, in the communities, the major themes for the interview are:

- i. Cultural practices and health seeking behaviours.
- ii. Knowledge of illness and health seeking behaviours.
- iii. Socio-economic status and health seeking behaviours.
- iv. Access to healthcare services and health seeking behaviours.

There were total of 12 items based on the 4 sub-scales. These qualitative data were to compliment the quantitative data from the instrument.

## Result And Discussion

**TABLE 1: Respondents rating on parental perception of knowledge of childhood illness**

S/N	Factors Statements	Rating %						Mean	STD
		VSA	SA	A	D	SD	VSD		
1	Hotness leads to illness	10	9	33	164	107	105	4.54	1.145
2.	Illnesses are caused by negligence	23	37	73	130	94	75	4.06	1.379
3	Loss of sleep is a sign of illness	56	68	163	65	43	37	3.19	1.401
4	Crying uncontrollably is a sign of illness	56	45	123	91	54	63	3.53	1.538
5	Eat regularly	29	58	109	103	64	69	3.75	1.456
6	Illness during teething	28	20	43	139	94	108	4.33	1.407
7	I hardly recognized any symptoms of illness	64	95	146	54	37	36	3.03	1.426
8	I recognize all symptoms	70	62	110	77	53	60	3.37	1.606
9	Irregular habit is a symptom	29	26	34	108	101	134	4.22	1.436
10	Eating regularly	34	20	43	153	82	100	4.22	1.436

**Source: Fieldwork, 2019**

Again, in Table 1, the respondents seem not to be knowledgeable of childhood diseases as most respondents gave correct answer to five (5) statements out of the ten statements in this sub-scale. Many respondents' (164 or 38.0%) do not know, that hotness of the body leads to illness; out of the 432 respondents, (146 or 33.8%) knew that all cases of children illness are caused by parental negligence; (123 or 28.5%) of the respondents knew that, most illness make children cry uncontrollably and redrawn. Also, out of the 432 respondents' (109 or 25.2%) agreed that when children are ill their feeding habit is affected; similarly, (146 or 33.8%) reported that illiterate patients can hardly recognize any symptom of illness in their children. Many respondents' (163 or 37.7%) do not know that loss of sleep could be cause by illness and (329 or 57.0%) do not know that it is natural for children to experience fever during teething. From the responses we can conclude that, the level of knowledge of childhood diseases among parents in the Central Senatorial District of Cross River State is moderate.

### Test of hypotheses

#### Parental perception of knowledge of illness and health seeking options

**H<sub>0</sub>:** There is no significant relationship between parental perception of knowledge of illness and their health seeking behaviour.

**H<sub>1</sub>:** There is significant relationship between parental perception of knowledge of illness and their health seeking behaviour.

Results presented in table 4.7, indicated that knowledge of illness was significantly related to the health seeking options of Parents. knowledge variables displaced in the table indicated that over forty percent of the variables was significant at 0.01 level of significance, while thirty percent were significant at the 0.05 level of significance.

**Table 2. Mean, Standard deviation and Pearson correlation matrix of the relationship between Parental perception of Knowledge of illness and Health seeking option.**

	Mean	Std. Deviation	PPK1	PPK2	PPK3	PPK4	PPK5	PPK6	PPK7	PPK8	PPK9	PPK10
1 Hotness leads to illness.	4.54	1.145	1									
2 illnesses are caused by negligence.	4.06	1.379	.223**	1								
3 Loss of sleep is sign of illness.	3.19	1.401	-.074	.036	1							
4 crying uncontrollably is sign of illness.	3.53	1.538	-.079	.231**	.374**	1						
5 eat regularly	3.75	1.456	-.058	.194**	.338**	.354**	1					
6 Illness during teething.	4.33	1.407	.137**	.229**	-.075	.127**	.100*	1				
7 I hardly recognize any symptom of illness	3.03	1.426	-.162**	-.007	.269**	.218**	.174**	-.067	1			
8 I recognises all symptoms	3.37	1.606	-.128**	.210**	.211**	.421**	.427**	.181**	.235**	1		
9 Irregular eating habit is a symptom	4.45	1.482	.082	.003	-.063	-.034	-.016	.080	.042	-.136**	1	
10 Eating regularly is a symptom.	4.22	1.436	.106*	.258**	-.018	.186**	.198**	.201**	.087	.150**	.255**	1

\*\*. Correlation is significant at the 0.01 level (2-tailed).

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From the table above, the null hypothesis that states that, there is no significant relationship between parental perception of knowledge of illness and their health seeking behaviour was rejected while the alternate hypothesis was retained. The correlation coefficient is a standardized measure of an observed effect, it is a commonly used measure of the size of an effect and r-values of  $\pm 0.1$  represent a small effect,  $\pm 0.3$  represent medium effect while  $\pm 0.5$  is a large effect.

Therefore, variance in health seeking behaviour is accounted for by knowledge of illness. The magnitude of effect is large. Again, the results showed a positive correlation coefficient (this is because of the negative sign of the r-value). Which implies that, an increase in the independent variable (knowledge of illness) directly results to an increase in the dependent variable (health seeking behaviour). Therefore, we can conclude that, there is statistically significant relationship between parental perception of knowledge of illness their health seeking behaviour. The result above supported the findings of the Focus Group Discussion a 37 years old business woman have this to say.

*Lack of appetite in my child does not necessarily means that he/she is sick, some-time it is an indication that, the food is not tasty or he/she want something else.*

Equally, another 38 years old discussant from Onyedama in Obubra LGA supported this view but added that;

*Loss of sleep some-times could be seen as a sign of ill health, but when the child still plays around the house, it then become very difficult to say truly that the child is sick some of my children hardly sleep naturally and I think they inherit such traits from my mother, that is they grand-mother. So, most time their sleeplessness is not surprising to me.*

Additionally, a 35 years old female farmer also have this to say;

*I notice that in my second child that irregular eating habit was a sign that he needs to be deworm but this is not so, about my first child who is a girl, in fact, as soon as my boy is deworm, he eats everything eatable.*

In another FGD session in Mkpani. A 42-year-old civil servant, male, have this say;  
*well, I hardly can recognize any sign of illness in a child except my wife points it out to me, I feel one must possess special powers to be able to dictate such thing. I use to find it very difficult to understand how those things work.*

More so, a 33 years old female discussant equally have this to say;  
*when a child is very hot, it does not mean that such a child is having fever or malaria, it could be a mere sign that the child wants to grow new set of teeth which to me not harmful at all to the development of the infant.*

This finding was also supported by the result of a Focus Group Discussion. See excerpt

In a Focus Group Discussion (FGD)' A 48 years old Female participant had this to say '  
*Any time I observes changes in my child behaviour or inactivity and drop in his/ her appetite, I quickly suspect fever, but if the symptom persists, I will enquire from a traditional healer, who most times doubled as a seer, for medical help and this have most time worked for me.*

In a Focus Group Discussion.

*A 33 years old participant, male had this to say 'I do not use the hospital for the treatment of my children's illnesses, because of lack of money, but only because certain illnesses are not for the hospital. Take for example, Measles attack is traditionally considered as a punishment for breaking family taboos or as an evil deed from witches or enemies and it is perceived as deadly disease among our people and cannot be considered a hospital illness.*

Again, in another (FGD) session

*A 32 years old parent, Female, had this to say 'I try to be careful which illness is for the doctors and the ones I can handled traditionally myself. Take for instance, in Ofoutop community, diarrhea is perceived merely as a means of getting rid of body impurities or as a sign of 'teething', 'crawling', or 'stretching'. Also, some parents believe that diarrhea is caused by consumption of sweet things and can simply be treated using enema (which is the use of some concoctions to deworm the child).*

This hypothesis states that, there is no significant relationship between parental perception of knowledge of illness and their health seeking behaviour. The free factor in this speculation is parental view of information on disease while the reliant variable is wellbeing looking for conduct. In the wake of testing the speculation, the result showed that there is a critical relationship view of information and wellbeing looking for choices of guardians with babies. This viewing as concurred with the aftereffect of a comparative investigations completed by (Owumi, 1996, referred to in Akpenpuum and Mpem, 2015). Which uncovered that distinctive conventional information, convictions, odd notions and folklore are solidly and well established in numerous social orders, these convictions and strange notion have direct relationship with their wellbeing looking for conduct and this was worked together by (Ojua, Ishor, and Ndom, 2013) in their investigations, which likewise



uncovered that, the discernment origination and the board of weakness are controlled by the social qualities/information on a gathering of individuals.

Chronic sickness exists in all social orders however, the perspectives about medical affliction and therapy shifts starting with one gathering then onto the next. The conviction arrangement of a gathering of individuals is implanted in a conventional society where the idea of illness is secured on enchantment strict variables. The gathering seems to have more noteworthy trust in the helpful abilities of the conventional healers than in those of western medical services organizations which individuals works on. Diverse conventional convictions, odd notions and folklore are solidly and well established inside our social orders and the way of life of a group has an immediate relationship with their wellbeing chasing behaviour.

### **Conclusion**

Based on the statistical analysis of the hypotheses, that gave a direction to the study; it was found that a considerable number of individuals don't have clear view of sickness and therapy while some appended the demise of under-five kids to odd notion This has a genuine ramification on under-five dismalmness and mortality in Nigeria.

A definitive objective of states all around the world is to delay the unavoidable 'Life ends' by decreasing mortality to low levels and guarantee the great soundness, all things considered. Be that as it may, disregarding an overall decrease in baby and kid mortality in creating world, the rates are still high by world norm. Regardless of the way that the Nigerian Wellbeing Strategy perceives the need to decrease the current high youth mortality, the people's conviction and conduct rehearses have not been satisfactorily coordinated into wellbeing intercession programs.

### **Recommendations**

Based on the findings from the study, the following recommendations were made:

1. It is very necessary to coordinate the people's convictions, perspectives and social practices into some local area wellbeing advancement projects to accomplish a most extreme decrease in youngster and newborn child dreariness and mortality rates.
2. Adequate health Education of parents especially nursing mothers from the foregoing is highly recommended particularly for those in the study areas. This can be achieved through the activities of the primary Healthcare delivery system.
3. Government should subsidize the medical charges (Users fees) or reintroduce free medical care for pregnant women and under 5 infants as it was during Governor Liyel Imoke's Administration in 2011-2015, particularly for the less endowed communities for better and adequate utilization of Health services not just for the rich, but also for the poor. This will motivate most parents to embrace modern Healthcare services thereby reducing their dependence on cultural practices in their Health seeking process.
4. Healthcare services should be improved via the primary healthcare unit in terms of adequate funding, supply of equipment and professional Healthcare providers. This will make such Health centres more attractive to users.

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