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Knowledge of Children on Harmful Traditional Practices, the Types and Regulations in Ghana

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ABSTRACT

Background: The paper aimed to examine children's awareness of harmful traditional practices (HTPs), the various types they are familiar with, the reasons for their persistence, and the effectiveness of national responses.

Methods: This study is a secondary analysis of both quantitative and qualitative data obtained from the Ministry of Gender, Children, and Social Protection, collected between April and October 2018. Descriptive statistics were utilized to analyze the quantitative data, while thematic analysis was applied to the qualitative data. The quantitative data set included 5,024 children aged 8 to 17, with males constituting 51.1% and females 49.9%. The qualitative component consisted of 10 focus group discussions and 50 key informant interviews.

Results: Overall, 88% of children were aware of HTPs that have an impact on them. HTPs identified by the respondents were early marriage, nutritional taboos, gender chores, female genital mutilation and menstrual taboos. The persistence of HTPs was attributed to ignorance, poverty, deeply rooted immersions in adherent cultures, and poor national and community regulations.

Conclusion: HTPs are widespread in Ghana, highlighting the need for policymakers to strengthen interventions and enforce policies enacted to address HTPs.

1 | Introduction

A group of people share a collective set of behavioural patterns known as tradition, which they pass down from generation to generation. It encompasses language, religion, types of food eaten, methods of cooking, child-rearing practices and many other cultural values that unite people and provide them with a sense of identity, setting them apart from other social groups [1, 2]. Each social group worldwide has distinct traditional cultural practices and beliefs, some of which are detrimental to certain groups of people [3, 4]. Harmful traditional practices (HTPs) are customs, beliefs and ways of life that can inflict bodily or psychological injury, death, stigma, fear or other undesirable feelings on people [5]. HTPs include female genital mutilation (FGM), forced feeding of women, early marriage, fertility control restrictions, nutritional taboos, traditional birth practices, son preference affecting the status of girls, female infanticide, early pregnancy and dowry payment [6, 7]. Certain populations worldwide continue to follow these practices despite their perceived harm and violation of human rights. Consequently, many governments and international organizations have prioritized the eradication of HTPs on their policy agendas [8, 9]. Several countries have implemented

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laws, policies, guidelines, public awareness campaigns and other measures to discourage and eliminate adhering to such practices [3, 9] To curb these practices, Ghana's government, through the Ministry of Gender, Children, and Social Protection and other state and non-state entities, has passed laws, developed policies, run programmes, educated communities and set up institutions [10, 11]. Despite these efforts, there is evidence that HTPs are still prevalent in some parts of the country. The Multiple Indicator Cluster Sampling (MICS) revealed that one in five Ghanaian women aged between 20 and 24 married before turning 18 [12], while the 2022 Ghana Demographic and Health Survey found that 16.1% of Ghanaian women aged between 20 and 24 married before turning 18 [13]. Also, prior studies have shown isolated occurrences of FGM in certain parts of the country [14, 15]. Although some communities still practice HTPs, their prevalence appears to be declining, requiring further efforts to reduce HTPs to the bare minimum.

The continuing prevalence of HTPs prompts questions about the effectiveness of the national initiatives carried out to address adherence to HTPs and whether there is a need for innovative strategies to enhance public knowledge, policy development and law enforcement within the country. To address these complex concerns and promote change in the country's adherence to HTPs, relevant knowledge backed by evidence is required. The paper aimed to examine children's awareness of HTPs, the various types they are familiar with, the reasons for their persistence, and the effectiveness of the government's national responses.

2 | Contextualizing HTPs and Implications for Children in Ghana

Ghana is a country of many indigenous traditions and cultural practices that have positively impacted the country's social, political, health and other social realities [16–18]. Nonetheless, Murove et al. [19] identified several cultural practices embedded in native marriage, rites of passage, family secrets and other sacred practices in Ghana as risks to children. Thus, understanding these traditional practices can greatly enhance the country's child protection commitment, signed under the United Nations Convention on the Rights of the Child (UNCRC) in 1990 [19–21]. Despite being the first country to sign the Convention on the Rights of Children (CRC) and passing several legislations to promote and protect children's rights [22, 23], the country has failed to promote children's participation in the child protection process and legislation [20] due to what has been termed 'old values and indigenous resistance to child's rights' [23, p. 156].

Despite the lingering uncertainties surrounding some of these traditional practices and systems, many remain essential for today's governance, health, religion and social development [24]. Both Quarshie [25] and Asubonteng-Manu et al. [26] contend that in Ghana, certain cultural practices, like puberty rights, have the potential to compromise children's rights; however, these practices hold valuable values that require modification and upholding. Conserving and valuing the traditional extended family structure of caring for the elderly and children is an excellent practice. Most African cultures, including Ghana, have rooted the 'ubuntu' (African humanism) cultural philosophy in an Afrocentric ideal and practice, emphasizing collective responsibility and communal or kinship care for children and older relatives [16, 17].

While most traditional practices in Ghana are changing, certain traditions and a broader cultural ethos are harmful to children in contemporary times [24, 27]. Ghana's history, politics and socioeconomic structures intertwine with traditional and cultural practices [27–29]. Several of these traditional practices tend to either enhance or hinder human freedoms and health, such as the trokosi, FGM and early and forced marriage [24, 27]. Religious and cultural belief systems underpin several of these traditional practices [26]. For instance, FGM, a practice in Islam, Christianity and traditional religions in Northern Ghana, involves the partial or complete removal of the external female genitalia using rudimentary devices, which can have severe health implications for the girl child. For cultural or non-therapeutic reasons, this practice often results in additional injuries to the female genital organs [27, 30].

Boateng and Sottie [27] have identified traditional practices and other cultural rites, such as widowhood rites, widow inheritance, FGM, female ritual servitude (trokosi) and early marriage in certain indigenous societies in Ghana, as harmful to women and the girl child. Ras-Work [30] persuasively argued that the 'trokosi' traditional practices in Ghana and other West African countries, which involve giving children (girls) to fetish shrines to serve as domestic and sexual slaves under threat, undermine the rights and freedom of these children. Owusu [29] contended that family members often invoke the 'trokosi' rite to prevent a superstitious communal tragedy. Furthermore, the girls used by their families in this cultural practice serve as atonement for any sins committed by a family member against the gods or local customs and traditions [29, 30]. Sometimes, families perform the 'trokosi' rites of atonement before the girl child is even born [30].

Children, particularly girls, are the target group in this traditional practice, both as potential and actual victims [27]. Modern societies may find some virtues in the practice of 'trokosi', which involves making people account for their sins, but the use of children puts their health and general well-being at risk [24, 29]. According to the traditional practice, the indigenous priest or shrine often receives the female virgins known as 'trokosi children' [29]. This traditional practice is predominant among the Ewe Indigenous group and violates multiple human rights laws, legislation in Ghana, and other international conventions, including the Ghanaian Criminal Code/Criminal Offences Act 1960 (Act 29), the Ghana's Children's Act 1998 (Act 560), and the United Nations Convention on the Rights of the Child [31].

Some cultural beliefs, sociocultural practices and attitudes in Ghana negatively impact child health, such as the use of Ghana's traditional medicine as the primary treatment for sick children [32]. Tagoe-Darko and Gyasi [18], however, have argued that several traditional beliefs and practices enhance child health in Ghana, such as breastfeeding, massage and postpartum sexual abstinence, while also instilling healthy cleanliness and eating habits in newborns and toddlers. Ghanaian

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traditional communities prominently practice caregiving, where parents leave their children with extended family members and close acquaintances due to work and other related factors [16].

Children in kinship care (CKC) experience several challenges due to an inadequate supply of basic necessities, educational neglect and emotional connection, which are mostly due to the limited financial and emotional resources at the disposal of these family and friends' caregivers [16]. On the contrary, Adama et al. [17] asserted that in Ghana, CKC tends to have a huge positive impact on children and preterm newborn care, and traditional herbal treatments are believed to help cure ailments among preterm infants and children. Thus, understanding cultural effects is critical when developing therapies for children and newborn survival [17, 18].

Child marriage in parts of Ghana is also gendered because, compared to boys, several children (girls) are forced into arranged marriages by their families or given away to shrines or fetish priests for marriage [29]. Research reveals that approximately 5% of young boys undergo forced marriages before reaching the legal age of 18 [12, 27]. Child marriage is most common in Ghana's northern areas, but it can occur anywhere, with rural communities having a greater prevalence rate than urban communities [33, 34]. Child marriage is prevalent among disadvantaged families in Ghana [12, 29].

Despite the contemporary legislation against HTPs, discriminatory customs, belief systems and practices against children, especially young girls, persist in Ghana, reflecting society's inhumanity and legal loopholes [27]. To protect children's human rights, it is essential to enhance education, law enforcement, community awareness, improvement of customs and traditions and collaboration among stakeholders [17, 18, 27].

3 | Methods

3.1 | Study Design and Sampling Procedure

This study used secondary data from the Department of Children (DOC) under the Ministry of Gender, Children, and Social Protection (MoGCSP). The DOC utilized a cross-sectional convergent parallel mixed-method design to collect data on the living conditions of children in Ghana. The study investigated the perspectives of children aged 8–17 on detrimental traditional practices in Ghana. The data collected encompassed the children's awareness of existing harmful practices, their familiarity with specific practices, their opinions on the continuation or discontinuation of these practices, and the reasoning behind their views. The analysis also included information about the country's response to HTPs. The qualitative data enhanced the quantitative data by contextualizing the explored themes.

We collected the quantitative data using a multistage sampling procedure. During the first stage, we selected 20% of the 216 districts in the country's ten regions, which resulted in the selection of 43 districts for the 2018 study. In the subsequent stage, we randomly selected 15 Enumeration Areas (EAs) from each of the 43 districts, resulting in 645 EAs for the study. During the third step, children between the ages of 8 and 17 living in households in each EA were eligible for inclusion in the study. We selected only one child aged 8 to 17 from each family to participate in the survey using the Kish grid approach. Door-to-door surveys use a Kish grid method to randomly select individuals for interviews within a household [35]. We conducted interviews nationwide with a total of 5024 children aged 8–17. During the pretest, we discovered that children aged 8–17 were intelligible enough to answer the questions, which supported our decision to include children in this age range.

The qualitative data included focus group discussions (FGDs) and key informant interviews (KIIs). We conducted a total of 20 FGDs, involving 10 children aged 8–17 and the remaining 10 adults. Participants were conveniently selected. These discussions occurred in a village in each of Ghana's 10 regions. Every FGD comprised a total of 8–10 participants. Additionally, we conducted five KIIs with representatives from various Ministries, Departments, and Agencies (MDAs) and Metropolitan Municipal and District Assemblies (MMDAs) across all 10 regions of Ghana. Overall, 50 KIIs were conducted nationwide.

3.2 | Study Setting

Ghana is categorized as a lower-middle-income country located in West Africa. It borders Burkina Faso to the North, the Gulf of Guinea to the South, Togo to the East and Côte d'Ivoire to the West. Ghana had 10 administrative regions in 2018. Ghana is comprised of 16 administrative regions (2024) following a nationwide referendum in 2018. Ghana's population is 30 832 019, with 6 535 747 children aged 0–17 (GSS, 2021).

3.3 | Measurement and Variables

'Whether children had knowledge of prevailing harmful traditional practices affecting children?' and 'Whether harmful traditional practices should continue or be discontinued?' were the dependent variables in this study. Children were asked if they were aware of HTPs that affect children, and their responses were either 'yes' or 'no'. Children who answered 'yes' were categorized as being aware of HTPs.

The independent variables for the study were sex (male and female), age (8–10, 11–13 and 14–17 years), education (No Education, Primary, Junior High School [JHS], and Senior High School (SHS)/Vocational/Technical/Commercial, and Tertiary), religion (Christianity, Islam, Traditional and no religion), and region (Greater Accra, Central, Western, Eastern, Volta, Ashanti, Brong Ahafo, Northern, Upper East and Upper West).

3.4 | Data Collection

The DOC collected data from April to October 2018. The DOC organized training for research assistants to educate them about the project, its goals and objectives, and guidelines on conducting interviews while following ethical norms. Research assistants received training in questionnaires and interview guides for both quantitative and qualitative data gathering

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instruments. The National Child Protection Committee of the DOC, within the MoGCSP, authorized this study as part of Ghana's 2018 Situational Analysis of Children. The secondary data used in this paper is part of the data collected to understand the situation of children in Ghana. The authors obtained permission to use the secondary data. Since the research relies exclusively on secondary data, ethical clearance was not necessary.

Research assistants recruited by the DOC secured written informed consent from parents or guardians before interviewing children aged 8–17. Furthermore, they obtained written assent from the children before conducting interviews. Due to the sensitive nature of issues related to HTPs, research assistants with at least 3 years of experience in collecting data from children were recruited by the DOC, and they were trained on how to create a conductive environment for children to freely share their experience, including sensitive information on traditional harmful practices. Furthermore, research assistants were trained to provide adequate time to children to recall and narrate their experiences. The DOC limited participation of children to those who acknowledged the existence of HTPs and expressed a willingness to share their experiences. Children who were either reluctant to disclose information or unaware of these practices were excluded from participation. The collected data was anonymised to protect the privacy of children.

3.5 | Data Analysis

Sociodemographic characteristics of the children were described using frequencies and percentages based on the quantitative data. The relationship between children's knowledge of harmful sociocultural practices and their sociodemographic characteristics was analyzed using Pearson's chi-square test. All statistical analyses were conducted using SPSS version 26, with variables considered statistically significant at a 95% confidence interval.

In the analysis of the qualitative data, all interviews were audio-recorded and transcribed verbatim. A thematic analysis was conducted using QSR NVivo version 10 to explore the transcripts. The focus was on assessing children's knowledge of prevailing traditional practices in the country, including the types they were aware of and the reasons for the persistence or discontinuation of HTPs. Participants' narratives were coded based on the study's objectives, and similar codes were grouped to generate themes. These themes and codes were then used to convey the participants' perspectives.

4 | Results

4.1 | Sociodemographic Characteristics of Respondents

Table 1 shows that 51.1% of children were male and 48.9% were female. Most children indicated they were Christians (75.1%), with those belonging to the Islamic faith making up 21.6%, African traditionalists being 2.1%, and those with no religious affiliation being 1.3%. Additionally, most children (43.7%) were in the age range of 14–17. Regarding education, 42.1% were in primary school, 31.5% were in JHS, 2.3% were in tertiary institutions, and 0.5% were not attending school. The Brong Ahafo Region had the highest percentage of children (14.7%), whereas the Upper West Region had the lowest percentage (4.3%).

TABLE 1 | Sociodemographic characteristics of respondents.

Variables	Frequency	Percentage
Sex		
Male	2566	51.1
Female	2458	48.9
Age		
8–10	1330	26.5
11–13	1497	29.8
14–17	2197	43.7
Educational attainment		
Not in school	27	0.5
Primary	2116	42.1
JHS	1584	31.5
SHS	1183	23.5
Tertiary	114	2.3
Religion		
Christianity	3771	75.1
Islam	1083	21.6
African Traditionalist	103	2.1
No religion	67	1.3
Region		
Greater Accra	360	7.2
Central	474	9.4
Western	377	7.5
Eastern	598	11.9
Volta	595	11.8
Ashanti	707	14.1
Brong Ahafo	738	14.7
Northern	722	14.4
Upper East	237	4.7
Upper West	216	4.3
Total	5024	100.0

Source: From the field data, 2018.

4.2 | Knowledge of Prevailing HTPs

Table 2 displays responses on the prevalence of children who knew of any prevailing HTP affecting children. This was asked to determine children's knowledge about such practices. Table 2 also shows the association between children who knew of any prevailing HTPs and the sociodemographic characteristics of

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respondents. Approximately 88% of children knew the prevailing traditional practices affecting children. Table 2 indicates that a nearly equal percentage of male and female children (88.2% vs. 87.4%, $p = 0.408$) reported having knowledge of the HTPs in the country. Moreover, children aged 14–17 exhibit greater knowledge of prevalent HTPs (89.9%), followed closely by those aged 11–13 (89.0%), while children aged 8–10 display a somewhat lower level of awareness (82.9%). There is a statistically significant association between the education level of respondents and knowledge of harmful practices ($p = 0.000$). Children in tertiary education (95.6%) reported higher knowledge, followed by those in SHS/Vocational/Technical/Commercial (90.3%), JHS (89.3%), primary (85.1%) and those with no education (66.7%).

According to Table 2, children affiliated with Christianity (89.7%) had the highest knowledge of HTPs. On the other hand, children with no religious affiliation (73.1%) had the lowest level of knowledge regarding HTPs affecting children. Also, more children in the Greater Accra (92.2%), Ashanti (90.4%) and Central (90.3%) regions had significantly highest levels of knowledge of HTPs than children in the Upper East (80.2%), Northern (82.1%) and Upper West (82.4%) areas who had a lesser level of knowledge ($p = 0.000$).

TABLE 2 | Information on children with knowledge of prevailing harmful traditional practices by sex, age, education, religion and region.

Variables	Knowledge of prevailing harmful traditional practices		*p* values
	Yes (%)	No (%)	
Sex			0.408
Male	2262 (88.2)	304 (11.8)	
Female	2148 (87.4)	310 (12.6)	
Age			0.000
8–10	1102 (82.9)	228 (17.1)	
11–13	1332 (89.0)	165 (11.0)	
14–17	1976 (89.9)	221 (10.1)	
Education			0.000
No education	18 (66.7)	9 (33.3)	
Primary	1800 (85.1)	316 (14.9)	
JHS	1415 (89.3)	169 (10.7)	
SHS/vocational/technical/commercial	1068 (90.3)	115 (9.7)	
Tertiary	109 (95.6)	5 (4.4)	
Religion			0.000
Christianity	3381 (89.7)	390 (10.3)	
Islam	901 (83.2)	182 (16.8)	
Traditional	79 (76.7)	24 (23.3)	
No religion	49 (73.1)	18 (26.9)	
Region			0.000
Greater Accra	332 (92.2)	28 (7.8)	
Central	428 (90.3)	46 (9.7)	
Western	338 (89.7)	39 (10.3)	
Eastern	535 (89.5)	63 (10.5)	
Volta	524 (88.1)	71 (11.9)	
Ashanti	639 (90.4)	68 (9.6)	
Brong Ahafo	653 (88.5)	85 (11.5)	
Northern	593 (82.1)	129 (17.9)	
Upper East	190 (80.2)	47 (19.8)	
Upper West	178 (82.4)	38 (17.6)	
Total	4410 (87.8)	614 (12.2)	

Source: From the field data, 2018.

4.3 | Types of HTPs Children Know

In the FGDs with children and adults held across 10 communities, participants generated a list of traditional practices characterized by the harm they have or know of and described how they are. The practices include early marriage (betrothals), nutritional taboos, chores assigned by gender, menstrual taboos, scarification and FGM (Figure 1). Subsequently, participants engaged in discussions to share their understanding and awareness of these practices.

4.3.1 | Early Marriage (Betrothals)

Early marriage was one of the prevalent HTPs mentioned by the children, and it was found to be widespread in practically all 10 districts of Ghana. The KIIs and FGDs revealed that child marriage traditions still prevail in some communities in Ghana. Children noted that the phenomenon affects many children, with girls being betrothed to prospective spouses as young as 5 years old. The agreement is frequently obtained and concluded with drinks between the bride and groom's families before betrothal. An elderly key informant indicated that after the arrangement, the prospective bride's family and her parents or family share responsibility for the girl's upbringing.

> *The agreement is frequently obtained and concluded with drinks between the bride and groom's family before betrothal. In the past, the desire to marry from a reputable family, where members are of good character, respectful, diligent, and judged to be responsible, inspired the choice of betrothal marriage. In other words, prospective brides were more inclined to reject marriage proposals from families with negative character qualities. Children who were betrothed to a respected member of the community were respected. As a result, family members investigated the family in question's background for any potential negative tendencies.*
>
> [KII 1]

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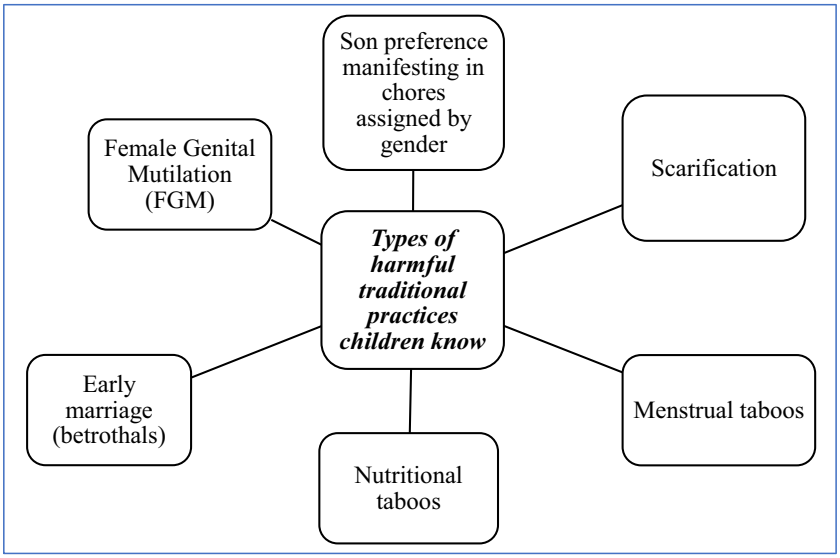


FIGURE 1 | Types of harmful traditional practices children know.

The KIIs with adults in some communities revealed that another cause for betrothal marriage was men's strong desire to marry virgins. Some of the KII participants expressed the following:

> *The females in betrothal marriages were morally obligated to remain chaste until they were formally married off. Most betrothal marriages were not considered legitimate relationships between husbands and wives until the two families formally announced and acknowledged them. It was thus the obligation of both families to keep them from having sexual relationships until they married.*
>
> [KII 2]

> *Most prospective husbands require virgin girls. Since virginity was very important in early marriages, many families took it seriously and ensured that their female members kept their virginity until marriage.*
>
> [KII 3]

The FGDs with both children and adults found that another cause for betrothal marriage was coercion, in which a girl was betrothed to pay off debts owed by her parents to the prospective husband's family.

> *Most of the families engaged in child marriage are those usually facing financial difficulties. Some family members marry off their daughters to pay off the debts of families. The dowry usually given by the prospective families usually includes cows, food stuffs, alcoholic beverages, and cash. Families in debt or dire need of cash sell off some of these items to settle their debts.*
>
> [FGD 2]

4.3.2 | Nutritional Taboos

The FGDs uncovered the existence of communities that continue to observe nutritional taboos. Participants described how females are prohibited from consuming eggs or meat due to the belief that if they are allowed to do so, they will pilfer eggs and meat from their future households after marriage. Some experiences were shared as follows:

> *In this community, girls are not allowed to eat meat and eggs. The elders believe restricting their consumption of eggs and meat during childhood can avert potential shame of stealing from their marital homes in the future.*
>
> [FGD 3, Girl 14 years]

> *Girls get an insatiable appetite for eggs no matter where they go after eating too many. Their prospective spouses may not have the financial means to support their egg-eating habits, which makes them a financial burden to them in the long run.*
>
> [FGD 4, Boy 13 years]

4.3.3 | Son Preference Manifesting in Chores Assigned by Gender

The FGDs uncovered the presence of son preference, which is evident in rural communities where boys are given greater preference than girls. The findings suggest that in certain societies, girls carry out household tasks. Within certain communities in the northern sections of the country, it is a traditional practice to exclusively assign the responsibility of collecting water for their households to female individuals. Some participants reported that it is inappropriate for males to fetch water since females are to serve men.

> *Sons are the family's primary source of income and must provide for the family's future. We must hold them in high regard since they will eventually earn money and care for their wives, children, and other family members. From childhood to adulthood, they are to be valued more than*

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females. This is why they are not allowed to handle women's household chores.

[KII 4]

Only females in this community are responsible for fetching water. If you are a male and are observed collecting water, people will perceive you as foolish. If you are a male child, your peers will mock you, and if you are a grown man, your colleagues will ridicule you, claiming that your spouse has enchanted you.

[FGD 5, Girl 15 years]

4.3.4 | Menstrual Taboos

The FGDs revealed that certain populations hold a traditional belief that women and girls are considered unclean during menstruation. As a result, they are forbidden from attending school, and to some extent, they are even deprived of the opportunity to cook for their families. This tends to impact the education and academic achievement of girls. Some girls shared the following:

Girls and women are not allowed to attend school in some communities when they are in their menstrual period. In some of the communities along the Offin River area, many girls stay out of school during their menstrual flow period to avoid the stigma associated with it. This affects their academic performance and their education in general.

[FGD 6, Girl 15 years]

During an interview with educational officials, they discussed the consequences of menstruation taboos on teaching and learning in certain communities. They stated:

Menstrual taboos prevalent in certain cultures have a bearing on the placement of female teachers in certain communities. Community members expect female teachers to conform to the taboos when they enter certain communities. Consequently, many female teachers have been pushed to seek transfers from those schools, while others decline postings to places.

[KII 3, MOE]

Girls' inability to cross a bridge from their villages to school is one reason they perform so poorly in nearby schools. This is because it is believed that the river deity views women as dirty when they are menstruating, which is why no woman crosses the river during this time. The catchment communities are impacted by this, as are the schoolgirls and teachers who live across the river without schools.

[KII, MOE]

4.3.5 | Scarification

KIIs and FGDs found Scarification as a form of HTPs in some communities. The narratives described it as the intentional process of creating marks on a person's face. FGD findings indicate that scarification is typically performed during early childhood, with multiple explanations and symbolic interpretations associated with the practice. Many children undergo the practice of receiving tribal marks at their outdoor ceremonies. Certain ethnic groups used it to augment the aesthetic attractiveness of their physical appearance and facial characteristics. For instance, some children who have undergone scarification reported their markings were intentionally created for the goal of decoration.

I got the marks on my face as a sort of decoration. Obviously, this was done many years ago and has been passed down to us, and it now appears to have some spiritual importance, as all members of my family perform it.

[FGD 8, Girl 11 years]

The KIIs found that Ghana's Fante and Ahanta tribes also practice scarification but refer to it as 'koasamba' in the Fante language, which means a reincarnated person. The KIIs revealed that families had encountered the unfortunate situation of losing their children shortly after birth and, after that, experiencing the heartbreaking repetition of their deaths. The traditional notion is that the departed child is a reincarnated person who returns to cause pain for their parents. Parents apply distinctive markings on their baby's face to circumvent the cycle of reincarnation. They believe that once these marks are present, the child will be easily identifiable and, out of fear of being discovered, will evade death and rebirth. A participant who asserted to have undergone the experience of her child's death and subsequent reincarnation shared the following:

My daughter has experienced two instances of death. I am certain of the accuracy of my statement as I experienced the loss of her when she reached the age of two. In the year that followed her demise, I became pregnant once more, and the infant girl had a striking resemblance to my deceased daughter. Regrettably, she also passed away. Upon the birth of my third child, we sought the guidance of our traditional priest, who suggested that we create a facial mark on the infant as a means of protecting her against potential death. My daughter is currently 14 years old.

[KII 4]

Some communities also believe that scarification can serve as protection for children from death, especially when they have had serious incidences of a certain illness, which nearly led to death. One child shared his experience:

When I inquired about the cause of the scars on my face, my grandfather informed me that scarification can protect a person from illness or curses. He mentioned that during my early childhood, I frequently fell ill and came close to losing my life. I was marked with scars to act as a means of spiritual protection, preventing evil forces from taking me to the land of the dead.

[FGD 12, Boy 14 years]

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4.3.6 | FGM

FGM was reported as one of the harmful practices affecting children. According to KIIs and FGD reports, although the practice has largely died out in the country, it is still practiced in remote communities. In an interaction with the District Health Management Team in Saboba, they confirmed that the practice is still in use and that the clinics only see a small number of cases when the complications of those who have engaged in it are brought to the health facilities for treatment.

> *Even though FGM is illegal here, people may do it discreetly or cross the border to neighbouring countries where it's easier to have it done. We are only able to find cases in our health facilities after they have it and developed complications they can't handle at home. I must admit that this practice has significantly decreased across the country.*
>
> [KII 5, GHS]

> *Every one of my three sisters has had female genital mutilation. I am the only female in my family who did not go through the process. Therefore, I guess I should count myself lucky. My parents passed away, so I ended up living with a friend of my father in the city.*
>
> [FGD 17, Girl 17 years]

4.4 | Reasons for the Persistence of HTPs in the Country

The study looked into why HTPs are still being followed in the country. In the focus groups and KIIs, children and adults gave reasons like ignorance, poverty, following a belief system, being deeply rooted in the cultures of followers, and weak national and community rules (Figure 2).

4.4.1 | Ignorance

Explanations offered regarding why HTPs are still prevalent in certain parts of the country during the KIIs indicate that adherence is borne out of ignorance. Respondents explained that many of the people still engaged in HTPs are ignorant, as most of them are also illiterate and highly susceptible to circumstances that expose them to being victims of such practices. Two participants expressed the following:

> *I forbid my sons from performing domestic activities, such as cooking, fetching water, or washing female clothing. Compelling them to engage in such behaviours will lower their status as male figures within the family.*
>
> [KII 6]

> *There are a lot of uneducated women in this town. Most of them were married off when they were young, so they never had the chance to go to school. Because of this, many women don't know how to read or write, have little say in family decisions, and are subservient to the will of their men.*
>
> [FGD 8, Girl 11 years]

4.4.2 | Poverty

The KIIs and FGDs revealed that poverty is one of the key reasons why many people continue to follow HTPs, even if they have no desire to do so. Some opinions stated included the following:

> *When I was a child, I never wanted to marry because I wanted to finish school, but my mother and aunts persuaded me to marry because my father had directed that I marry to save the family from poverty.*
>
> [KII 8]

> *My father refuses to let us eat meat and eggs because he claims they are forbidden, but I know he does so because he cannot afford to buy enough meat and eggs for the entire family. Even though I don't eat eggs and meat at home because they are considered taboo, I do so when I visit my friends' homes or go out to eat with them, and nothing bad happens to me.*
>
> [FGD 9, Girl 15 years]

4.4.3 | Part of a Belief System

Some participants' expressions indicated that a considerable proportion of HTP adherents recognize some of the practices as part of their belief system, which can protect all devoted and committed believers. Two participants had these to express to corroborate:

> *I follow customary practices to protect myself and my family against witches and wizards in our family and the wider community. In this village, if a menstruating woman cooks for the family, she brings a curse to the family. Hence, only females who are not having their period prepare for the family.*
>
> [KII 9]

> *Nobody in this neighbourhood steals. This is because if you dare to steal, you will face the wrath of the gods and die whenever lightning strikes. The elderly members of our society have constantly shared old stories about persons who have engaged in theft and subsequently died as a result of being struck by lightning. The veracity of these stories remains uncertain, although the elders have employed them effectively to persuade a significant number of individuals, resulting in their adherence to the HTPs.*
>
> [FGD 10, Boy 13 years]

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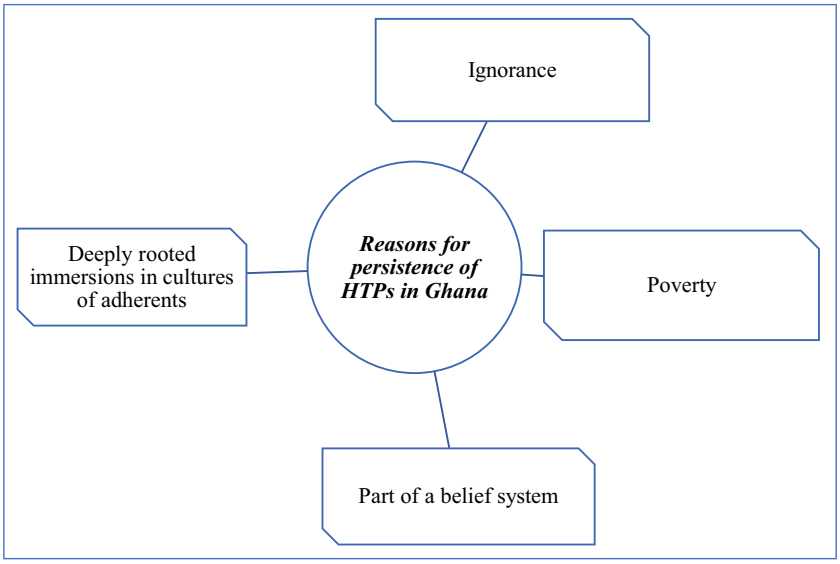


FIGURE 2 | Reasons for the persistence of HTPs in the country.

4.4.4 | Deep Rooted Immersions in Cultures of Adherents

Adherents of some HTPs do so because they are deeply rooted in their culture and have become a part of their existence, making it difficult to change. Some participants of the adult FGDs explained:

> *You'll be astonished to learn that there are people who have migrated out of their villages and are now living in cities yet continue to practise some HTPs. Traditions, once entrenched in an individual, are extremely difficult to abandon. This is why many people struggle to break free from certain HTPs.*
>
> [FGD 11]

> *Because these customs define our way of life and the kind of people we are, changing them would mean changing who we are, which is a tough task. Because of this, a lot of people find it hard to change. Many perceive that they will lose who they are if they don't follow the norms.*
>
> [FGD 12]

4.4.5 | Poor National and Community Regulations

The FGDs revealed that HTPs have persisted and continue to be widespread in certain parts of the country due to inadequate national and community legislation that fails to discourage adherence to HTPs or encourage modifications to these practices for adherence. Children expressed the following:

> *Despite its position as a democratic beacon, Ghana continues to practise infant marriages. Several adherents ought to be imprisoned, but they are permitted to move freely in their communities. We are too slack in enforcing our laws and policies. This explains why some people take advantage of it.*
>
> [FGD 13, Boy 17 years]

> *Some traditional activities, which are considered detrimental but which people continue to follow because they cannot leave them, could be modified while remaining in practice. The failure to modify some practices and the fact that adherents cannot discontinue them explain why people continue to practise old, harmful practices.*
>
> [FGD 14, Girl 16 years]

4.5 | National Responses to HTPs

4.5.1 | Regulations

Officials from the DOC, DOG and the Domestic Violence Secretariat of the MoGCSP reported that the government has taken enormous strides in establishing and fortifying the policy environment to facilitate more effective measures to deter individuals from participating in HTP. Some statements made by the officials to corroborate them are as follows:

> *We have strengthened the policy environment to deter individuals from participating in HTP and other forms of violence against children. The Child and Family Welfare Policy and the Justice for Children Policy are two newly introduced policies. These two policies aim to strengthen justice and child protection at the local level to advance children's rights.*
>
> [KII 10, DOC]

> *My organisation has consulted extensively on HTP concerns in our regions over the past 20 years. Developing a strategy to involve religious and traditional leaders in combating gender inequality and destructive cultural practices is one of our most recent flagship efforts. For a more nuanced understanding of the risks associated with these HTPs, the Framework will be an awakening.*
>
> [KII 11, DOG]

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The government has formed the National Child Protection Committee with representatives from government, non-governmental, and other civil society agencies and groups. The Committee's purpose is to identify and address child protection issues that adversely affect children, engage in discussions about them, and develop solutions for them. The Committee's formation has been instrumental in highlighting and addressing several issues affecting children that would have otherwise gone unnoticed.

[KII 12, DOC]

The Ghana Against Child Abuse (GACA) campaign, which attempts to prevent all activities that contribute to child abuse and its negative consequences, is currently active and well-supported throughout the country. UNICEF funds the programme and has played an important role in raising awareness about the harmful effects of HTP and the repercussions of engaging if caught.

[KII 13, HTS]

4.5.2 | Major Achievements Made in Addressing HTP in the Country

Interactions with personnel from the Department of Gender (DOG), the Department of Social Welfare (DSW), and the LEAP Management Secretariat revealed that the government has made significant efforts to combat HTPs that adversely affect children. The officials noted in the interactions that steps have been taken to enact laws, formulate policies, enhance poverty reduction initiatives, and increase awareness to alter attitudes towards these practices. At the DOG and DSW, two officials shared the following:

We have made enormous gains towards eradicating harmful traditional norms, the majority of which affect women and children in our diverse communities. However, persuading some members to cease these habits has been difficult. Given the prior hurdles, we are currently developing a framework to include traditional authorities and faith-based leaders in our efforts to eliminate gender inequity and harmful cultural practices throughout the country.

[KII 14, DOG]

The MoGCSP seeks to eradicate detrimental cultural practices and enhance support for gender equality all over the districts by involving governmental and non-governmental groups. We believe the interactions will help people gain the information and confidence to bring up discriminatory concerns in their communities, have productive conversations about them, and ultimately find solutions.

[KII 15, DSW]

The MoGCSP coordinates the Livelihood Empowerment Against Poverty (LEAP) programme. As the name implies, the programme aims to enhance the living conditions of particularly vulnerable households facing exceptionally difficult poverty situations. The LEAP project has a strong relationship with HTP adherence. This is because many HTPs occur because of people's poverty, which renders them powerless and unable to fight for their rights. Thanks to the programme's monetary subsidies, many needy households can escape these practices.

[KII 16, LEAP Management Secretariat]

4.5.3 | Challenges in Addressing HTP in the Country

The CHRAJ and DOC stated in the KIIs that Ghana's statutes protect children from torture, cruel, inhuman or degrading treatment or punishment. According to CHRAJ officials, Ghana has enough legal instruments to combat all forms of child abuse. The problem has been to instil trust in those affected to report instances to the appropriate authorities so that the legal procedure can begin.

These forms of treatment are prohibited under the Constitution and can result in criminal charges under the Children's Act and the Criminal Code (Amendment) Act of 1994 and 1998. We face a hurdle with persecution since many cases go unreported, hindering the initiation of necessary legal procedures. We continue to raise awareness to encourage individuals to report cases of violence against children.

[KII 17, CHRAJ]

At the DOC, another officer made the following statement, which was consistent with the CHRAJ report:

With the abundance of policies and laws, I often question the continued existence of these widespread practices in the country. We must acknowledge that we are addressing cultural beliefs that have persisted for many generations and cannot be changed quickly. To enhance our educational efforts, we should utilise community engagement strategies and leverage social media due to the widespread internet usage in the country.

[KII 18, DOC]

It has been an arduous challenge to carry out our projects without sufficient funding, but we have accomplished several great things to encourage individuals to stop practising HTP. We could do a lot more if we had the resources to reach out to the rural areas where HTPs are most common. Right now, we are only working at half capacity. Coincidentally, we are limited in our ability to visit some communities due to the constraints imposed by our resources. Regrettably, our options for resolving this issue are limited.

[KII 19, DOC]

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5 | Discussion

Using a cross-sectional convergent parallel mixed-method approach, this study investigates children's awareness of HTPs, the types of HTPs they are familiar with, the reasons for their persistence, and the effectiveness of national responses to these practices. This study contributes to the existing literature on children's knowledge of HTPs, their continued prevalence, and the challenges and achievements in mitigating these practices within the country. The outcomes will provide foundational information for child rights education, law enforcement, community awareness, modifications of practices and traditions and stakeholder collaboration.

The findings reveal that HTPs are pervasive nationwide, with 88% of children reporting awareness of these practices. This level of awareness is slightly lower than that observed in earlier studies focused on adolescents in three communities in Rivers State, Nigeria [5]. The widespread awareness among children underscores the continued existence of HTPs in the country, highlighting the urgent need for a robust, nationwide initiative to combat these practices.

The KIIs and FGDs revealed that early marriage remains prevalent, particularly in the Northern regions. These early marriages are often consummated through familial arrangements involving the exchange of drinks between the families of the bride and groom, indicating a deep-rooted complicity within families. Financial challenges, cultural customs and the preference for virgin brides among potential husbands contribute significantly to the persistence of child marriage. The consequences of child marriage are severe, including early sexual activity, early pregnancies, illegal abortions, pregnancy complications and even maternal death [7, 36]. These findings underscore the need for the government to reassess and strengthen its strategies to ensure that no child is subjected to marriage.

FGDs also highlighted the existence of nutritional taboos in several communities, where young females are forbidden from consuming eggs and meat under the belief that they will steal these foods from their future homes after marriage. These taboos disproportionately affect girls, restricting their dietary intake during childhood. Previous research indicates that food taboos are prevalent in various countries, and our findings align with this existing documentation [37, 38]. While the rationale for excluding girls from consuming certain foods may appear unfounded in modern times, the persistence of these taboos suggests that some communities still believe in their efficacy in preventing theft during marriage.

Our study also reveals that traditional practices dictate that only female members of the household are responsible for collecting water, reinforcing gendered divisions of labour. These findings are consistent with previous research, which shows that sons are expected to be the primary earners for their families and are thus exempted from domestic chores [39, 40]. This gendered expectation fosters a sense of superiority among males, who may view household responsibilities as beneath them. Such practices negatively impact daughters, who bear the brunt of household chores, leaving them with little time to focus on their education [8, 41, 42]. Raising awareness and promoting gender equality in household responsibilities are crucial steps in addressing these deeply ingrained practices.

The FGDs further revealed the prevalence of menstrual taboos in certain communities, which prevent females from participating in social and economic activities. These findings corroborate earlier research [43, 44], demonstrating that menstruation is often perceived as a contaminating force that limits women's and girls' participation in various aspects of life. For instance, some communities prohibit menstruating girls from attending school or preparing meals for their families. These taboos negatively impact girls' academic achievement and may deter teachers from accepting placements in communities where such practices are prevalent. Additionally, certain religious and cultural practices, such as the isolation of menstruating women in cowsheds in rural Indian Himalayan communities [45], further illustrate the far-reaching consequences of menstrual taboos. Educating girls, their families and entire communities about menstrual hygiene and dispelling myths surrounding menstruation are essential steps in mitigating these harmful practices.

Scarification is another traditional practice identified in some communities. This practice involves deliberately creating facial marks on infants for various reasons, including beautification, sickness prevention and warding off death. While these practices may have been well-intentioned, they often result in stigmatization. Previous studies indicate that individuals with tribal facial marks are frequently subjected to mockery, being perceived as outsiders, slaves or even offspring of the devil [46, 47]. Such derogatory treatment can lead to significant psychological distress, particularly among children who may become introverted and socially isolated as a result. This, in turn, hampers their academic progress and performance. The government should consider legislation aimed at banning tribal markings and enhancing public education to prevent the mockery of individuals with such marks.

Furthermore, our findings indicate that FGM continues to be practiced in remote communities, despite its illegal status in Ghana [48]. FGM is widely recognised as a serious violation of human rights and is associated with severe physical and psychological health issues [49]. Although the incidence of FGM has decreased, it persists, particularly in the Northern, Upper East and Upper West regions [14, 15, 50]. Strengthening education and law enforcement in these areas is crucial to eradicating the practice.

The narratives from the FGDs and KIIs suggest that ignorance among adherents is a significant factor contributing to the persistence of HTPs. This finding aligns with previous research, which indicates that ignorance can perpetuate misconceptions and justify the continued use of harmful practices [8]. Enhancing education is an effective strategy for eliminating ignorance and promoting the abandonment of HTPs. The DOG, within the MoGCSP, should lead efforts to educate communities and raise awareness about the dangers of these practices.

Additionally, both children's and adults' accounts affirm that poverty is a key determinant in the continued adherence to HTPs. Previous research in Ghana [51], suggests that

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impoverished individuals may feel compelled to participate in HTPs even when they do not believe in them. Effective government measures aimed at alleviating poverty could significantly influence people's behaviour, empowering them to reject harmful practices. This is supported by the findings of KIIs with government officials overseeing the Livelihood Empowerment Against Poverty (LEAP) programme.

The adherence to HTPs is further reinforced by the belief that these practices are integral to individuals' religious and cultural identities, providing protection and guidance to those who remain loyal to them. This deep-seated adherence poses a challenge to efforts aimed at modifying or relinquishing these practices [52, 53]. The findings highlight the importance of understanding the cultural and religious significance of HTPs when designing communication strategies and outreach programmes.

Finally, the KIIs indicate that the persistence of HTPs in certain regions of the country is partly due to insufficient national and local regulations. These regulations fail to effectively discourage the use of HTPs or promote the adoption of alternative practices. This underscores the need for enhanced national initiatives to reduce adherence to HTPs, as noted in Ghana's report to the UN Committee on the Rights of the Child [10, 54].

While there have been efforts to curb HTPs in the country, including legislation, criminal prosecution, policy formulation and public awareness campaigns, these measures have not been entirely successful. The challenges faced by national entities in implementing these initiatives, particularly due to inadequate funding, hinder progress. Strengthening institutional capacities and securing adequate resources are essential for effectively addressing HTPs.

5.1 | Strengths and Limitations of the Study

The main strength of this study is its large sample size, specifically the quantitative data. However, the study has some limitations. The findings of this study may be biased since respondents had to recall their experiences. Also, convenient sampling was used to select participants for the FGDs. Therefore, those findings cannot be generalized as the views of all children aged 8–17 and adults across the country. Despite these limitations, this study contributes to the literature on HTPs.

6 | Conclusion

Most children are aware of the prevalent HTPs, confirming the existence of the practices in the country. The most common HTPs asserted to harm children include child marriage (betrothals), food taboos, gender-based assignment of household chores, menstrual taboos, scarification and FGM. The country's traditional practices, rooted in gender, disproportionately harm children, particularly girls. Factors such as ignorance, poverty, strong commitment to belief systems, deep immersion in adherent cultures, inadequate national and community regulations, and the involvement of families and communities contribute to the persistent prevalence of HTPs in the country. To effectively tackle the phenomenon, it is crucial to bring together all efforts with the aim of empowering families and communities to empower HTP victims. The MoGCSP must intensify its awareness-raising on the adverse effects of HTPs, and deliberate measures should be taken to enforce legislation. More research into the reasons for the continued prevalence of HTPs is also needed to determine why national initiatives have been ineffective in reducing adherence. To change adherent attitudes, policymakers and implementers must devise new ways, complemented by behavioural change programmes.

Author Contributions

Conceptualization: Sylvester Kyei-Gyamfi, Frank Kyei-Arthur, and Afisah Zakariah. Methodology, formal analysis, writing – review and editing: Sylvester Kyei-Gyamfi, Frank Kyei-Arthur, Afisah Zakariah, Kwami Sefa-Kayi, Emmanuel Yeboah-Djan, Robert Kwame Degraft Agyarko, and Evans Sakyi-Boadu. All authors read and approved the final manuscript.

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Ethics Statement

The study received approval from the National Child Protection Committee of the Ministry of Gender, Children and Social Protection.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The materials used for the study are available upon request.

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