Research Paper

Negotiating hygiene and sanitary behaviors in transnational contexts: examples of Nigerians in the UK

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ABSTRACT

The paper seeks to understand the extent to which hygiene and sanitary attitudes/practices are reproduced in transnational contexts using examples of Nigerians in the UK. In-depth and semi-structured interviews, participant interaction, secondary resources, follow-up interviews and informant discussions were important data sources. Issues discussed in this paper incorporate hand, body, dental, food and domestic hygiene and sanitary matters. The results show that not much has changed in hygiene and sanitary behaviors of the respondents despite having changed the environment and contexts of livelihood activities. The modest, recorded improvements in some behaviors can be attributed to the presence of basic infrastructures and services that unavoidably influence their utilization for some respondents. The paper argues that people do not necessarily aim for good hygiene and sanitary behaviors for health reasons as much as moral, social and certain cultural values. The desire to look good, be clean, eliminate discomfort, avoid bad bodily odor and gain social acceptance were the underlying driving reasons for sustaining good hygiene and sanitary living; health concerns were less important. Key elements of these findings hold practical prospects for addressing the hygiene and sanitary behavioral challenges for developing countries.

Key words | diaspora sanitary habits, health, Ibibio, knowledge, migrants, UK

INTRODUCTION

The hygiene and sanitary behaviors of individuals represent the symbolic markers of capacity for self-governance as they emphasize such issues as self-awareness, order and discipline, responsibility, parenting background, and the broader structural, institutional and environmental contexts of ‘growing up’. Horton & Barker (2009) used what Ross (1993) termed ‘capacity to exercise citizenship’ to discuss the various daily hygiene and sanitary measures expected for fulfilling the official standard of ‘sanitary citizens’ upheld by US standards of personal hygiene. Such standards revolve around the elimination of ‘personal odors’ through practices such as bathing, the use of deodorant and mouthwash, and the brushing of teeth, which formed the basis for drawing sanitary boundaries among individuals. A study by Horton & Barker (2009) on the histories of racial exclusion practices in the United States concluded that State judgments of immigrant groups’ capacity for self-governance in the area of sanitary and hygiene practices was the basis for racial exclusion practices against immigrants and foreigners.

Attaining the ideals of good sanitary and hygiene citizenship has much to do with structural and individual characteristics. The structural aspects can be located in State practices and expectations (through regulations), dominant cultural ideology, socio-economic characteristics, and the influences of the environment. State intervention through regulatory practices and promotional activities was central to driving changes in hygiene and sanitary behaviors in Europe and the USA in the late 18th century (Jenkins et al. 2010). The rise of modern States has been associated with enhanced interest in public health services.
and regulations, as documented in Horton & Barker (2009, p. 788, citing Lupton 1995): ‘...the epidemics of 17th and 18th Century Europe left an enduring legacy of the State being considered responsible for the public’s welfare. Until the early 19th Century, the emerging discipline of public health relied primarily on emergency measures such as quarantines to address periodic outbreaks of epidemic disease...’

While the benefits of sanitary regulations, improved infrastructures, increasing professionalization in the public health domain, and the application of science and technology have enhanced the attainment of improved hygiene and sanitary practices in developed countries, enormous challenges are still being encountered in attaining a similar feat in less developed countries of the world as these conditions weakly apply. Cultural norms and religious beliefs (confounded by a range of socio-economic and environmental contexts) still shape dominant worldviews of hygiene and sanitary matters especially in countries in Africa and some parts of Asia.

But what happens to individuals who have developed in a context of strong cultural influences on dominant hygiene and sanitary behaviors attempting to re-establish their lives in another context where such influences are absent? Specifically, and in an era of globalization and cross-border migration, what factors are likely to influence the dynamics of hygiene and sanitary behaviors of migrants moving from the less developed countries to the developed countries, with differences in environment, regulatory system, medical landscape and standards in public health practices? This question is addressed specifically by examining the perspectives of hygiene and sanitary behaviors of Nigeria’s Ibibio ethnic group resident in the UK.

DECONSTRUCTING THE HYGIENE AND SANITARY BEHAVIORS OF THE IIBIOS

Nigeria’s Ibibios (concentrated in Akwa Ibom State, south-south region), despite slight dialectical differences, are united by common ancestry, shared beliefs, traditional values and system of governance (Udo 1985; Faithmann 1999; Ikono-Ini Research & Documentation Committee [IRDC] 2001). Although Christianity has emerged as the dominant religion following colonization (over 90% are Christians), instances of ancestral worship, libation and incantations, beliefs in witchcraft, sorcery and taboos demonstrate syncretic tendencies, though in subtle forms.

Notions of health and sickness are anchored on the wider traditional/indigenous Ibibio worldviews of health and well-being as the product of the interaction of an individual with the wider socio-cultural and supernatural environment. In many parts of Africa, health and well-being are believed to be determined by the dynamic unity and harmony of the body, mind and soul – to the extent that sickness or ill health would automatically imply a ‘discord in the social body’, a ‘rupture of life’s harmony’ or the ‘activation of supernatural forces’ (Good 1987, p. 14, cited in Madge 1998, p. 294). This hardly fits with the western scientific explanation of health and illness. Three broad illness categorizations are recognizable as natural, mystical and inherited (Izugbara & Duru, 2006). Natural causes of sickness include drinking of unclean water, over eating, lack of rest, overindulgence in sex, ingestion of poisonous substances, and exposure to inclement weather. However, episodes of sickness that defy simple remedies and cannot be immediately linked to natural causation are often attributed to the activities of the gods, ancestors, deities, and spirits. Witchcrafts, errors in rituals, infraction of taboos and the neglect of deities are also listed in the realm of mystical causes of sickness. The inherited has to do with the hereditary transfer of some illnesses from parents to their offspring (p.33). Although these categorizations draw from the Igbo (Nigeria) ethnomedical cosmology, the Ibibios share a similar worldview as the immediate and closest neighbors distinguishable mainly by language dissimilarities. The Ibibios conduct their medical practices within the framework of individual health experiences/histories, tradition and religious beliefs, in addition to patronage of the modern biomedicine in some contexts (see also Ekong 2001; Ajala & Wilson 2013).

Hygiene and good sanitary behaviors are part of social, moral and community norms, which are never consciously directed at improving health and wellbeing. Physical cleanliness is believed to be an important aspect of beauty, reinforced by a common Ibibio saying: ‘nsana idem ado nsana idem ado ntutu’ (cleanliness is beauty), which encourages all forms of practices that keep every part of the body and the surrounding spaces clean (Table 1).

Physical hygiene and sanitary living address a range of issues including regular bathing, keeping the teeth clean, keeping the fingernails clean and short, regular combing of
the hair, curbing some negative bodily odors, and sustaining the cleanliness of immediate domestic and surrounding spaces, including the toilet and bath facilities. These are part of daily routines in families; e.g., waking early from bed, washing hands and face, brushing teeth, sweeping the house and surroundings, washing utensils, and bathing oneself. Children are repeatedly disciplined along these routines at the family level, and it is one of the yardsticks for judging how properly a child was brought up.

It makes some sense linking bodily hygiene and cleanliness with beauty as in nsana idem ado uyai, which helps, in principle, to emphasize the positive values of good hygiene and reinforce conscious behaviors for sanitary practices. However, where practices with obvious potential implications for hygiene and sanitary norms are tangled with myths, beliefs and superstition, these ideals of sanitary citizenship may be compromised (Akpabio 2012). But how do these behaviors adapt in changing environments and circumstances? This paper seeks to measure the dynamics, focusing on the potential for stability and change in hygiene and sanitary worldviews of Ibibios in diaspora. The main question seeks to understand the extent to which dominant hygiene and sanitary attitudes are reproduced in different contexts.

**THE STUDY PROCESS**

This project started in 2009 as part of a larger project investigating local meanings and attitudes shaping behaviors, practices and attitudes to water, sanitation and hygiene (WaSH) among the Ibibios in Nigeria. A range of cultural, socio-economic, and environmental factors was observed to influence local WaSH-related knowledge, attitudes and behaviors. These findings prompted the current interest and inquiry into the influences of such factors in

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**Table 1 | Selected hygiene and sanitary issues and their worldviews**

<table>
<thead>
<tr>
<th>General attitudes/practice</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily cleanliness</td>
<td>Provides an incentive for regular daily bath; It is a social taboo to stigmatize a woman by calling her dirty</td>
</tr>
<tr>
<td>Dental care</td>
<td>Long standing habit in the rural areas; urban and younger generations most likely to depend on tooth paste and brush; Poor or non-utilization of the modern dental services</td>
</tr>
<tr>
<td>Sanitary/hygiene related sicknesses (e.g., diarrhea, cholera, dysentery etc.)</td>
<td>Mostly blamed on food types or seasons, while severe or abnormal cases are linked to spiritual attack (idoho nkana, utoro ikpu, utoro anwa ifot etc.)</td>
</tr>
<tr>
<td>Sanitary myths and taboos</td>
<td>Abandoning an infant with convulsions or epilepsy in a rubbish dump site, for some hours, to secure healing; Local beliefs in the therapeutic values of ‘dirts’, including human excrements/waste products, etc.; ‘Germs never kill Africa’ is occasionally invoked to justify the unavoidable use and consumption of potentially contaminated food</td>
</tr>
<tr>
<td>Sense of hygiene and sanitation</td>
<td>Mostly for conforming to some social and moral expectations and standards as well as to avoid some social stigmatization</td>
</tr>
<tr>
<td>Hand washing after toilet use</td>
<td>Depends on individual feelings and judgments</td>
</tr>
<tr>
<td>Food hygiene (washing and covering food etc.)</td>
<td>Epidemiological concerns rarely considered</td>
</tr>
</tbody>
</table>

transnational contexts among individuals of similar ethnic affiliations in the UK.

The Ibibio ethnic group constitutes a small proportion of the over 500,000 Nigerians estimated to be living in the UK. Ascertaining the actual number of Ibibios in the UK was difficult. However, estimates should fall in the region of only a few hundred. Notwithstanding their various settlements’ locations, the Ibibios are well connected and are easily united through diverse spaces of engagements and transactions including the associational/ethnic network and relationship (ethnic association, kinship relations), social media (Facebook, WhatsApp, Skype), spiritual and religious settings (churches, spiritual centers), and business places (African/Nigerian shops, open/second hand markets). These spaces/platforms exist to unite and to encourage the reproduction of cultural values and medical idioms in a manner often discussed as important avenues of successful cultural globalization (Robbins 2004).

To have some insights into how the Ibibio worldviews of hygiene and sanitary living have adjusted in transnational contexts, a total of 24 migrants were subjected to in-depth and semi-structured interviews in July and August 2014, with follow-up interviews in May 2015. These exclude a special Skype interaction I had with three individuals who had previously spent several years in the UK. A large number of voluntary participants were tracked in London, Aberdeen and Dundee in churches, family visits and ethnic associational meetings facilitated through previous arrangements with a few known Ibibio indigenes in the UK. Each interview slot lasted on average between 45 and 70 minutes. All interviews were conducted in the Ibibio language. The follow-up interview provided ample opportunities to spend time with three families, and participate in domestic chores including cooking and occasional cleaning. Such moments afforded great insights and relative knowledge of family settings, especially the components of the kitchen, toilet system, and related issues. Beyond the three families, five other Ibibio indigenes that had participated in the previous interviews were visited to further clarify some issues.

The main interview sought to compare the diaspora hygiene and sanitary behaviors with the key issues in Table 1 to evaluate what is most likely to change or persist and why, especially in the context of transnational experiences. Notes on important points were taken throughout the interview. The results of each day’s interview were immediately sorted, coded and relationally classified on the basis of socio-demographic and economic characteristics to account for commonalities and differences between respondents, and to compare with available/previous narratives and prevailing norms of Ibibio behaviors. Follow-up interviews and informant clarifications were sought on some conflicting issues or when further explanations were needed. Given the very small number of Ibibios identified, every adult (from 18 years) was automatically accepted for participation provided there was willingness and interest.

The relevant ethical documentation and approval was secured at Kyoto University (Japan) and the University of Oxford (UK) before the actual fieldwork. During the fieldwork process, all ethical concerns related to anonymity, confidentiality, informed consent, and the ability to withdraw from participation were thoroughly addressed.

Several limitations of this study are hereby acknowledged. One, a fraction of data from a single and small ethnic group (the Ibibios) in the UK alone is not generalizable for a multi-ethnic Nigeria. While this study focused on comparing the experiences and behaviors of Ibibios within the context of transnational migration, no direct and follow-up fieldwork was organized specifically for migrants’ (interviewee) relatives who are resident in Nigeria. This gap was however bridged by previous studies on the same ethnic group (Udo 1983; IRDC 2001; Akpabio 2012; Akpabio & Brown 2012; Akpabio & Subramanian 2012; Ajala & Wilson 2013).

Two, this fieldwork was not designed to include the UK public health/medical institutions beyond a little information from secondary sources (see Krause 2014). As the health/medical experiences of migrants take place within the contexts and influences of the UK medical landscape and environment, findings from this study cannot be said to be truly objective without some inputs from the relevant UK public health institutions.

Finally, several fieldwork challenges including difficulties in tracking down busy respondents, unwillingness to disclose vital information and some inconsistencies in information provided by most respondents were encountered, and addressed through persistent follow-up interviews and informant discussions. It is worth re-stating that the UK aspect of this study was exploratory, and given that a study
of this nature should be based on long-term ethnographic data, the findings obtained here should not be unduly generalized. Despite these limitations, this study offers useful insights to encourage future research.

RESULTS

Socio-demographic and economic characteristics

Most respondents arrived in the UK between 2000 and 2009, but the rate of new arrivals is likely to be higher in the light of the high number of Ibibios migrating to the UK in the last five years beginning from 2010 (Table 2).

A relatively higher number of female participants was recorded during the interview. Given that over 70% of the respondents were married (with children), the male spouse is more likely to be involved in outside businesses and livelihood pursuits in deference to the Ibibio traditional norm and role of man as the ‘breadwinner’ in the family. This partly explains the relatively low turnout of male participants during the interview.

Most respondents (54%) were educated up to University level, 25% had High School Certificates, while 17% were educated up to college level. Most of the respondents were over 30 years old. It was not possible to have respondents in the 18–29 age bracket during the interview process, but most parents’ discussions actually addressed some issues pertaining to this age bracket. The first round of the interviews (July–August 2014) did not feature intensive participatory interaction in homes of most respondents except for occasional visits, while the second round (May 2015) actually coincided with the school sessions, as most prospective participants in that age bracket were in their respective school dormitories. However, some informal interactions with two respondents in this age bracket were useful for strengthening discussions.

Household settings

Based on spending at least 48 hours with each of the three families, the kitchen and toilet systems were the most important entry point for understanding the dynamics of hygiene and sanitary practices. All of the households sustained the modern systems of kitchen and toilet, equipped with relevant facilities and a stable supply of water. Over 90% of the food items in the kitchens were unavailable in the British supermarkets, including a bag of gari (cassava product), some beans, yam tubers, plantain, palm oil, and different types of meats including goat, etc. There were always spaces for a small percentage of other food items, fruits and beverages including cornflakes, bread, tea, milk, oranges, bananas and apples, depending on the family. The toilet systems equally had all the trappings of modernity in contents: water system, toilet papers, baths/showers, soaps, body lotions, towels, toothpastes and brushes, etc. In some cases, the traditional rectal bulb syringe and soap were also found.

The home, which serves as the domestic space for migrants and the family, primarily represents the basic spatial unit of social relations, where feelings of belonging and attachment serve to strengthen cultural and symbolic values and identity among families, friends and ethnic relatives. Within the context of transnational migration, the
home becomes more complex and multi-dimensional, and is central to migrants’ lives (Wiles 2008: in Lee et al. 2010, p. 109). The home becomes the first landscape for discussing, practicing and displaying all forms of hygiene and sanitary beliefs, attitudes and behaviors, in addition to managing health-related consequences. For a people who believe in multiple causes of sickness, food types and habits would certainly be important in addressing a range of possible sanitation and hygiene related sicknesses, including intestinal problems such as diarrhea, cholera, and dysentery. These kinds of sicknesses are sometimes blamed on food types, seasonal changes or, in severe cases, spiritual attacks (Table 1). The kitchen provides the platform for procuring, keeping, processing and utilizing familiar, indigenous food, products and services. It equally offers the needed privacy for conducting some healing and self-treatment processes which cannot be handled by the biomedical system. The narrative of one respondent (in her early 30s) who is married to a British man on how she manages intestinal problems reinforces the role of the home as an important therapeutic space:

‘...I no dey for that [implying she does not subscribe to biomedicine]...when I am sick, I run to the nearby bush and select some leaves for [enema]...that is how I was brought up...’

She went on to recount how she uses the same health care practices in taking care of her two-year-old son when he is sick:

‘...my husband most times sit and watch me with surprise how I handle my son the way I learnt from my parents...I hardly go to the hospital or visit a physician...’

Most of the respondents believe they are healthier, stronger and less susceptible to most public health related problems as compared with the situation with the ‘white’ population. One woman explained why she encourages her children to eat indigenous food:

‘...I persuade them every day and encourage them to eat our indigenous food instead of pizza, burger or some of these western food all the times...they can lead to some unexpected problems which we may not be able to manage...’

Linking most public health-related sicknesses with certain types of food and other factors has already undermined the needed capacity for cultivating and sustaining sensitivities to good hygiene and sanitary behaviors for public health reasons.

Hygiene and sanitary practices

There have been remarkable improvements in hand washing practices, which include washing hands ‘with’ or ‘without’ soap after toilet use in the UK over Nigeria. The margin of improvement was highest by over 26% in: ‘hand washing after toilet use’, and over 4% for ‘hand washing with soap after toilet use’. Slight improvement was also recorded for ‘hand washing before food preparation’ by over 8%, while the practice of washing fruits before eating improved by over 3% margin. Though changes were marginal in some cases, improved sanitary infrastructures in the UK probably could account for some adjustments in related behaviors. Although some of the respondents may have been exposed to a similar level of modern domestic infrastructures in kitchens and toilets in Nigeria, slight differences in hygiene behaviors could probably be due to differences in the regularity of water supplies between the two locations. Poor access to public water supplies in Nigeria encourages costly private initiatives and efforts, which often leads to some rationing of supplies for domestic and other activities. People’s hygiene and sanitary habits and behaviors could be affected by availability and access to related infrastructures (see Naikoba & Hayward 2007; Curtis et al. 2009). But considering the health values of hand and food hygiene, it would seem rather odd that some of the respondents have not integrated such habits in their daily hygiene and sanitary routines. Perhaps this trend could be explained on account of relatively poor socio-economic backgrounds (overwhelmed by the need to make much money and send remittances to cater for larger family responsibilities), or poor knowledge of the epidemiological and health impacts of sanitary and hygiene behaviors.

The respondents actually paid less attention to body hygiene (daily bath) and dental care in the UK. The number
that still maintained their daily and regular bath went down by over 50%. Seasonal changes in the UK weather especially in the winter were the commonest explanation for the slight adjustment in such habits. Most respondents agreed that a regular bath, for them, is still the normal and long-standing routine except in the winter, ‘… but whatever is the case one must bath at least once in a day…’ argued a male respondent in his late 50s. The symbolic notion of beauty linked to cleanliness is probably the underlying reason.

For dental care, brushing the teeth early in the morning has been an important element of mouth hygiene among the Ibibios. A child is always taught to wash the face and brush the teeth first thing in the morning before breakfast. Surprisingly, there was a self-reported improvement in this practice for Ibibios in the UK by 5%. Use of chewing sticks for toothbrushes declined by over 26% in the UK. Such findings were not mutually exclusive to a ‘yes’ or ‘no’ answer, as most respondents claimed the use of chewing sticks as an occasional complement to modern toothbrushes and pastes. Using a chewing stick for dental care carries some health implications for many who believe in it as one man pastes. Using a chewing stick for dental care carries some health implications for many who believe in it as one man pastes. The respondent went on to add that ‘…I always bring them each time I travel home…I can also buy them here…’ Respondents who bring chewing sticks to the UK make careful selection of the type depending on the medical and health values particular species of plants offer to the teeth and the health system in general.

The utilization of professional dental services among the respondents was not significantly different from previous behaviors in Nigeria. Respondents who claimed to engage in regular dental care mostly did so for the sake of their children, due to a lack of supply of an extensive network of informal structures, ethnic products and traditional services (including grandparent services) for supporting child care. There was an interesting narrative from a family on the dental structure of their last born son, which according to them was ‘embarrassingly irregular and wrongly positioned’. The wife said when they enrolled the boy in the school, their attention was immediately drawn to the boy’s dental problem and he was subsequently referred to the dentist for treatment. The parents were happy that the problem had been successfully solved. This context demonstrates an acknowledgment of the capability of the western medical system by the discussants. However, the case of a male respondent in his early 40s was different, and seems to emphasize his belief in the potency of his ethnic medical system:

‘…I had one occasion to visit a dentist and she asked me when last I visited a dentist…I told her I have never done that in my life…shocked, the woman invited her colleague to examine my teeth…they had expected some problems or decay, but they did not see any…they were surprised…’

The respondent went on to add that ‘…all these roots of plants and chewing sticks we use are very good…I keep using them once in a while since I cannot detach from such habit…’

Mixed attitudes on the potency or otherwise of specific health care products and services over the other have to do with a diverse range of factors including personal experiences, circumstances of exposure and, to a large extent, the influence of economic factors. The diverse accounts provided by respondents suggest that the contexts of individual and household experiences can serve to reinforce or undermine dominant attitudes and consequently influence potential choices over particular health care pathways.

DISCUSSION AND CONCLUDING REMARKS

Not much has changed in the hygiene and sanitary behaviors of the Ibibios in the UK, despite having changed the environment and contexts of livelihood activities. Modest improvements in hand hygiene can be attributed to the presence of basic infrastructures and services that considerably influence their utilization, though a few respondents were relatively ‘unmoved’ under such circumstances. Much of the basic hygiene and sanitary practices of the respondents were influenced by a complex mix of practiced routines, individual health experiences and histories, influences of socio-economic backgrounds, climatic differences, and differences in basic health care culture, availability of familiar ethnic health care products and social network. These factors were confounded by a probable lack of capacity to understand the health benefits of good hygiene and sanitary behaviors. Most respondents’ patterns of sickness experiences are already part of their
general health care knowledge, none of which could possibly be imagined within the scope and logic of hygiene and sanitary living. Poor knowledge and understanding of the epidemiological logic and health impacts of inappropriate hygiene and sanitary behaviors render the prospects of some behavioral changes relatively difficult for some.

The physical environment, social network and economic circumstances have been instrumental in encouraging the reproduction of hygiene and sanitary related habits and routines, attitudes and beliefs among the migrants. The availability of familiar ethnic products and services in the UK, the growing spaces and opportunities for all categories of familiar religious platforms, and the convenience of the domestic arena, imply relatively unfettered access and utilization of all forms of familiar ethnic products and services capable of addressing routine behaviors and needs. These probably contribute to limiting the possibility of opening up to new information, practices and behaviors as needs arise. It will be difficult to imagine having to depend on the biomedical system, which in the UK will likely entail extra time and complicated processes of appointment, in addition to the likely challenges arising from racial differences, language barriers and privacy concerns, among other issues.

Among the Ibibios, ideas of diseases and sicknesses draw on multiple sources, which can further be subjected to diverse interpretations depending on the severity of illness. The biomedical services and diagnosis system in the UK can hardly cope and agree with the patient’s perspectives, while the procedures for accessing the western health care services equally would not conform to migrants’ health care culture. Within these contexts, diseases and sicknesses that could otherwise be linked to poor hygiene and sanitary living are given different meanings, which tend to encourage various forms of non-biomedical solutions including self-management, spiritual exercises and the use of familiar ethnic products and services. These practices are conducted within the home, religious and business settings, depending on individual interpretation, beliefs, previous health experiences and histories as well as economic circumstances.

Nonetheless, the UK environment, society and health care system have served to influence some hygiene and sanitary behaviors of migrants in two ways. From one perspective, a coordinated and an efficient sanitary infrastructure with regular services has influenced some improvements in related behaviors as observed in the case of hand washing after toilet use. Based on the logic of Anthamatten & Hazen’s (2011, p. 95) landscape effect of public infrastructures, the paper argues that the presence of well-funded public sanitary infrastructures and water services has served to encourage appropriate sanitary and hygiene behaviors among the respondents. On the other hand, the UK’s highly organized biomedical-based health care services and institutions leave less space for accommodating alternative health care pathways symbolized by migrants’ health care practices. As already argued, differences in notions of health and health care culture limit proper integration of the migrants in the UK health care system despite claims by some migrants of having enrolled in national health insurance in the UK. This leaves room for most or even all forms of self-management, self-treatments and other alternative health care behaviors.

The main argument in this paper is that people do not necessarily aim for good hygiene and sanitary behaviors for health reasons but, rather, for moral, social and cultural values. The desire to look good, be clean, eliminate discomfort, avoid bad bodily odor and gain social acceptance were the underlying reasons for good hygiene and sanitary living, not concerns for possible health implications. These findings hold some implications for developing countries in the areas of improving sanitary and hygiene behaviors. Just like it took a serious epidemiological disaster in Europe (e.g., the great stink in London) to attain improved knowledge on the epidemiological and public health impacts of hygiene and sanitary behaviors, developing countries need some measures of capacity building including necessary education and awareness promotion on the link between hygiene/sanitary practices and health outcomes/diseases to influence some attitudes. The positive experiences of the parents of the child with the dental problem, to a large extent, influenced their attitude towards the biomedical health care system. Given the high social and moral premium placed on hygiene and sanitary living, efforts in capacity building could build on such pathways to strengthen the desirable values. Findings also seem to partly imply that improvements in hygiene and sanitary behaviors could be achieved in an atmosphere of infrastructural availability and the
regular sustenance of related services including water. Access to sanitary infrastructures and associated services has the potential to build up good habits over time. For this to be successful, developing countries need strong State involvement in public health matters, given the huge investments and social benefits involved.

As discussed earlier, the assumptions drawn from this study may not adequately apply in all contexts and circumstances given some obvious limitations. More so, matters of hygiene and sanitary behaviors among the Ibibios are most times tangled with cultural and religious beliefs, which have not been fully and deeply covered in this paper. This leaves room for further research.

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