

HOME PRACTICES IN CARING FOR
CHILDREN AGED 0-6 YEARS WITH
FEVER TO PREVENT FEBRILE CONVULSIONS

BY

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DECLARATION

I declare that the work presented in this study for the Bachelor of Nursing Science Degree, has not been presented elsewhere either in part or whole and it is not currently submitted for any other degree.

Signed:*L.M. Chapuma*.....
CANDIDATE

Approved By:*P. S. S. S.*.....
SUPERVISING LECTURER.

D E D I C A T I O N

Dedicated to my late father Mr. A. A. Mawenda who endured his illness to his death without my knowledge in his attempt not to disturb the completion of this study. His guidance I will always miss.....

A B S T R A C T

The birth of primary Health care requires nurses to critically analyse the resources used in the health care delivery service. One such resource is the home care provider, the one who gives the care to the sick member of the family at home. The study using the Orem's theoretical framework of self-care examined the home practices performed by the home care providers who looked after children with fever at home to prevent febrile convulsions.

Data were collected from a sample of sixty (60) adults who had brought febrile children to Kabwata Health Centre in Lusaka. An interview schedule was the tool used to collect data from the home care providers because it was assumed that most of them would be illiterate due to the high illiteracy rate in the country which presently stand at about fifty-four (54) percent (Grant, 1985).

The findings of the study reaffirmed the women's traditional role of caring for the family sick member. The identified self-care practices used in the care of a febrile child included administration of medicines like cafenol which were bought from nearby shops and spirins, or any other available left over medicines from previous prescriptions. These practices have an important implication to the nurse because they can be dangerous due to their harmful effects from overdosage, underdosage and intoxication to the febrile child. This means homecare providers have to be taught, to render their practices safe.

Other practical measures clients used to control fever on the febrile child were either tepid sponging or hot baths. The study highlighted the limited knowledge the clients had to engage safely on these practices. The clients had indicators for decision making on termination of self-care practices. For example they stopped the care due to non-response to the treatment they gave, they also terminated the practice when the child's condition was severe and also when they lacked experience and resources. These are equated to Orem's (1980) parameters for self-care practices.

In conclusion the findings for the study pose a challenge to the nurse to work in collaboration with the clients, families and communities so that safe self-care practice in communities become an achievable reality; more so, when dealing with problems of a febrile child in the home.

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CHAPTER 1

INTRODUCTION AND OPERATIONAL DEFINITIONS

1. INTRODUCTION

The practice of care for the members of the family in the homes by its own family members is as old as man has lived. However, the records of such practices are non-existent because man only knew how to read and write after the pre-historic era. Dolan (1973) affirms that from the time of the first mother down to the present day, women are found protecting children and caring for the elderly and sick members of the family.

It is known from observation that home-care is practiced but what is unknown is the efficacy of these practices. The study sought to determine the specific practices of care for the febrile child in the home. The reason being to gain information on the practices which would be used to discourage harmful practices; modify the practices which pose uncertainty on their usefulness and promote the safe practices performed by the home-care providers.

The interest to conduct the study arose after reading the world Health Body's intent of achieving the set goal of health for all by the year two thousand (2,000). In the Alma-Ata declaration of 1978, it is stressed that the health goal is to be achieved through primary health care, which emphasized the need to make health care the responsibility of the individual family and community at the cost the country could afford at every stage of the country's development in the spirit of self-reliance and self-determination (WHO, 1985).

The new strategy of health care delivery service requires the consumer of health to be an active participant in her own care. This came about because developing and developed countries alike realised that health care delivery service is becoming expensive in terms of money, time and personnel. This responsibility for health care in the family implied self-care. Cumper (1984) states that to have a balance on the cost of primary health care, poorest countries should be expected to make use of traditional community resources, to economize on cash expenditure. Practices which are harmful are costly in terms of children's disabilities and life loss.

Included in the traditional community resources are the safe practices of the home care providers on whom the study is focused. Homecare practices are intertwined with culture. William (1976) states that children everywhere are born into two external worlds. The first, is the physical and geographical surrounding like the dry heat of the arid desert or the ice of the arctic. The second world is the culture that is interconnected systems of customs, ideas and behaviours that have been created for them by their elders and ~~ancestors~~. Indeed, the practices of care of a sick child in the home is pre-determined by the culture of that community.

Fever is a common illness which occurs in many homes especially in children because it is associated with many conditions common in infancy and childhood. It is a problem on which little is done for, in terms of relief. Experience has shown that where action of care has been taken, some of the practices on control of fever seemed unsafe for example, over-dressing a febrile child would lead to febrile convulsions; this is one such practice which

should be discouraged. Inhalation from hot herbal fomentation could lead to herbal intoxication; again such practices would need to be used selectively with the assistance of a qualified traditional healer who is conversant with the safety of such herbs.

Since the new approach of health care delivery service demands of the health worker, not only to control disease but also to help communities to create a better use of resources, it is necessary to identify some of the practices on the control of fever in a febrile child. Werner (1984) cautions that fever itself is not sickness, but high fever can be dangerous especially in a small child because it causes brain damage which can lead to life-long disability. The concept of primary health care demands that health workers understand the people they are serving if their teaching has to be effective. It is therefore necessary to first assess what is being done in the Kabwata community so that teaching can be built on the existing cultural safe practices. Mtonga (1985) avers that patients participation in their own care seemed to play a major role in promoting independence and maintaining one's dignity, similarly, building on the safe practices on control of fever in a febrile child would promote confidence of the home care providers and in turn they would render a safe service, at the cost they can afford.

In these days of ailing financial economy, it is wise to look for cheap practical practices as solutions to the problems, that is maximizing the use of the available resources. The use of tepid sponging to reduce the fever in a febrile child at home would spare the home care provider from midnight travels to a clinic.

This, however, can only be achieved when health workers recognise the home care provider as a co-partner when dealing with health and illness matters in the home. The purpose of the study, therefore was to assess the home care practices that constitute safe and unsafe self-care in the control of fever and prevention of febrile convulsions in children aged 0-6 years. The information gained in the study is to be incorporated in teaching of safe self-care practices to the home care providers served by the health centre. It is hoped that the results of the study will make nurses and other health workers appreciate the role of the home care provider in the health care delivery service. The findings of the study hopefully will stimulate nurses to think of ways and means of promoting safe home care practices for the sick child in general and the febrile child in particular. The objectives of the study are as follows:

1. To establish self-care practices which are undertaken by home care providers to control fever and prevent febrile convulsions before seeking medical help.
2. To identify harmless home practices in the control of fever and prevention of febrile convulsions and encourage them through health teaching.
3. To identify harmful home practices in the control of fever and prevention of febrile convulsions so that they can be discouraged through health teaching.
4. To assess the parameters used for decision- making for continuing with self-care in home practices of control of fever and prevention of febrile convulsions.

2. OPERATIONAL DEFINITIONS

The terms used in the study are defined as follow:

Adult: Refers to an individual aged twenty (20) years and above and takes care of a child with fever at home and brings the child to the health centre for further management.

Children: Refers to infants and early childhood of age 0-6 years.

Febrile Convulsions: Fits without primary disease of the nervous system. A complication of the uncontrolled fever (King et al, 1983).

Fever: Monitored by home care providers as "hotness of the body".

Home: Dwelling place, fixed residence (Fowler et al, 1977).

Home Care Provider: An adult who gives care to a febrile child in the home and brings that child to the health centre for further management.

Home-Practices: Care activities which an adult carries out on children having fever, in an effort to reduce that fever in the home setting.

Self Care: Refers to the initial actions the adults take to control fever before seeking help from health personnel.

CHAPTER 2

THEORETICAL FRAMEWORK

The study utilized Orem's (1980) theory of self-care as base for conceptual reference. Orem's theory of self-care was chosen because the practices identified in the study are self-care practices. Leahy and Cobb (1982) say that theory usage by the researcher differs markedly from usage by the practitioner; the researcher seeks to create knowledge whilst the practitioner seeks practical directions that would lead her to potentially successful outcomes. Self-care activities assist individuals, families and communities to be responsible for their own health until they recognize the limits of self-care and be in a position to seek assistance outside their domain.

Orem (1980) defines self-care as clients' ability to give care to themselves if they are adults. In case of children (as it is in the present study) who require care from others because they are dependant due to their being in early stages of development physically, psychologically and socially, it is the care the provider gives to the infant or the child. Orem names the giver of such care as a dependent care agent.

Orem's theory of self-care is based on the philosophical understanding that man is a biological organism with rational power to care for himself. The self-care practices which man undertakes have a purpose, they have patterns and they follow a sequence. If these practices are effectively implemented, they contribute in special ways to human structural integrity, human functioning and development. The theory explains further that man has the capacity to engage in self-care practices but also has limitations at times whereby there is need for support.

Orem (1980) theorizes that the self-care actions are based, firstly on man's universal self-care demands which include the basic human needs of air, water, food, rest, elimination and social interactions. Secondly, these self-care practices are based on the developmental process with conditions and events occurring during various stages of the life-cycle.

Thirdly, the component is based on the health deviation demands whereby the individual or the dependent care agent determines the limitation of self-care and seeks assistance from outside to be able to come back to self-care.

The self-care concept implies that when individuals, families and communities are able to get the basic needs referred to as universal demands, they are able to adjust on the health-illness scale; but when they fail they are unable to do so.

Then, nursing personnel need to step in and assist the individuals, families and communities accordingly so that the individuals, families and communities are able to cope with the demands and return onto the health illness continuum.

Orem (1980) then divides nursing into 3 systems to meet the stipulated demands. The first nursing system is referred to as the wholly compensatory system; whereby the nurse or the health care provider does everything for the client/patient. The second system is the partly compensatory system; in this situation the client/patient does accomplish parts of the self-care practices but the nurse compensates on the areas where the client or patient has demonstrated inability to engage in the needed self-care practices. The third system is the one whereby the client/patient accomplishes self-care and overcomes self-care limitations; this system is termed by Orem (1980) as supportive educative system.

In this system the nurse merely gives support and education.

It is to this third system that the study mainly addressed itself.

Though it is realized that patients/clients have the ability to care for themselves, it is also recognized that at times the patients/clients are handicapped and unable to cope with the situation because of the overwhelming limitations caused by the health deviation demands. Thus, nursing service has to come in to assist the individual/family to return to the normal health illness continuum. For the nursing service to accomplish this task effectively it needs to base its activities on culturally and scientifically reasoned practices.

There is therefore a need to determine some of the home care practices in relation to current nursing trends. The study recognized the fact that it is the duty of the community nursing service to effectively give care to an individual family from cradle to the tomb. It was also realized that communities, being served practice self-care on health deviation occurrences such as symptoms of fever in children. Therefore the study sought to identify the self-care practices and limitations that led the home care providers to the decision of seeking help from nurses, resulting in nurses prescribing the support and care to be provided.

The study looked at the symptoms of fever in children of age 0-6 years which was a common crisis in many homes. Fever was being viewed as cause of health deviation self-care requisites as it fell in the health deviation category according to Orem's (1980) classification. Children with fever have to be looked after by mother/home care providers using the wholly compensatory system.

The study sought to identify the parameters which these home care providers utilized to terminate self-care before they sought partially compensatory care at the health centre. Though fever would fit in Orem's classification of developmental life process; the study viewed fever in children as a health deviation demand so that the educative supportive nursing system would be emphasized to the home care providers. The results of which would be conduction of safe practices in the home of a child with febrile condition. In essence this would promote self-care practices which are needed for the achievement of primary health care. In conclusion the self care theory by Orem (1980) served as a practical guide for the study on home practices of control of fever; it provided a foundation for determining the practices, the limitations, the parameters and the nurses' baseline for making decisions in promoting care agents' ability to care for children with fever and supporting them when they required assistance to maintain their health illness balance.

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CHAPTER 3

STATEMENT OF THE PROBLEM

Fever is a common childhood symptom observed in many homes. It is not an illness in itself, but a sign of many different illnesses. However, it is one of the conditions which makes parents and significant others to queue in the out-patient departments of many hospitals and health centres. High fever is dangerous especially in small children, because it can cause convulsions. Werner (1980) states that if fever is not controlled, it results in febrile convulsions which can complicate to brain damage, paralysis and mental slowness.

Parents and families do take some actions to control fever at home but it has been observed and experienced that those practices which can be referred to as self-care practices in the control of fever at home are rarely encouraged amongst the communities of the developing countries. Kleczkowski (1984) stated that in developed countries due to increasing complex new technology, there was a greater reliance on specialized knowledge as such there was decrease in capacity for self-care. Is the situation experienced in developing countries like Malawi and Zambia on self-care practice any different from that of the developed countries? Experience and observations have demonstrated the fact that self-care is practiced but not monitored. Thus the home self-care practices on the management and control of fever in children aged 0-6 years needed to be examined and evaluated.

Time and again, clients frequenting the out-patients' departments of the hospitals and the health centre^s are those with fever. The hospital beds of a significant number are occupied by children faced with complications resulting from uncontrolled fever. The results of these frequent visits to health centres and the long stay in hospitals cause stress to families and cost countries a lot, in terms of time and money. Thus, the situation stimulated the need to study the practices of those who handled the fever crisis on their own in the homes. The decision was made because it was hoped that the findings would help to determine the support the families would require in managing children with fever at home as health cost saving measures.

Taylor (1984) stipulated that the primary responsibility of health personnel was to help communities to solve their own problems and care for themselves. Indeed, encouragement of families and communities to perform self-care activities in controlling fever would go a long way in promoting self-reliance and responsibility for clients' own care.

Hence, it became necessary to determine the home practices in the control of fever in children aged 0-6 years since the practices contribute to the health delivery services positively or negatively. The study therefore, sought to answer the research question; what are the self-care practices in the home management of children with fever?

The hypotheses for the study are as follows:

1. Knowledge of parameters for decision making on self-care assist home care providers to continue with self-care or to seek outside help.
2. Home care providers who have formal education practice more self care in the home before seeking help from health institutions.

3. Lack of parameters for decision making make continuity of self care unsafe.
4. Some home-practices on the control of fever are harmful and render self-care unsafe.
5. Harmless home practices of controlling fever in children aged 0-6 years indicate safe self-care practice.

In conclusion, it was envisaged that the determination of self-care practices on controlling of fever at home in children 0-6 years old would provide information for promotion of safe self-care through health teaching. This in turn, would reduce overcrowding in health centres and hospital out-patients' departments. It would further lessen **anxieties** experienced by home-care providers when faced with convulsing children due to uncontrolled fever. The exercise of safe **measures** of controlling fever at home enhance the potential contribution of self-care which Kleczkowski(1984) referred to as an increased social accountability of health care which enables individuals to formulate better judgement regarding appropriateness and satisfactory nature of health service.

CHAPTER 4

LITERATURE REVIEW

Although some research has been done on childhood hyperpyrexia in some parts of Africa, the focus of the studies has been to find clinical conditions associated with hyperpyrexia and determine the final outcome of cases studied, (Obi,1982).

Since there are fewer studies done on practices on home management to control fever and prevent febrile convulsions pertinent literature to the study has been hard to come by. However, Orem's (1980) theory of self-care has been applied as a theoretical framework for the study because the nature of the context of the practices identified in the study are viewed as self-care practices.

Self-care is a relatively new concept in nursing to this part of the world but in traditional practice, it has been carried out, though not monitored. Orem (1980) stated that self-care is purposeful and its activities are meaningful. The reasons for studying the self-care practices on control of fever in the home were to identify the practices which are harmful and those which are harmless so as to promote clients' participation in their own care. Self-reliance is achieved by the persons giving care in the home when they fully participate in self-care practices. In the study the care givers of children having fever were identified as either parents or other adult relatives. Self-care practices in the study dealt with activities performed by the care providers whose children aged 0-6 years had fever. The care providers had to relate the initial actions they took to control fever at home in order to prevent complications of febrile convulsions which could occur if fever was left uncontrolled

Fevers, as cited by Adegoreye (1984) are common occurrences among the population of the developing world especially those living in the Malaria Zone. In all fevers, there are general dysfunctions of all systems of the body depending on the cause of the fever. The significance of fever as the ~~cause~~ of convulsions in children is well documented in literature. Chamberlain (1979) found out that 85 percent of convulsions were said to be febrile. Adegoreye (1984) stated that in children between ages one(1) and two(2) years, the convulsions are more common due to any condition where there is sudden high fever, to irritation of the nervous system by toxins and other foreign bodies in the brain caused by malaria, middle-ear-infection, gastrointestinal infectious diseases as well as measles and meningitis. This means to have a worthwhile study on the prevention of the convulsions, one had to know the cause of the fever, and the practice would be based on the cause. Prevention of convulsions is important because of the fear of the possible effects on the child's brain which may become damaged if oxygen supply to the brain was interrupted.

Identification of self-care practices on control of fever are mandatory in this respect. Levin (1981) argued that self-care was certainly not the exclusive practice of industrialized societies and that it was not only appropriate to countries with high literacy rates and high standards of living. On the contrary, self-care was a dominant mode of health care for most people in developing countries. In developing countries such as Malawi and Zambia, with the birth of Primary Health Care as a means of delivering health services, safe self-care practices entail a look at these practices. The Malawian National Seminar on Primary Health Care held in 1978, suggested community participation as the means to achieve the health goal of health for all by the year 2,000. This meant self-care practices like

Home care to children with fever. Similarly, Health by the People (1981), a report on implementing Primary Health Care in Zambia, also emphasized community participation in Primary Health care by identifying problems which could be solved using the available resources; these resources were to include the people themselves, such as the home care providers of the study.

UNICEF/WHO (1981) reported that community participation referred to arrangements which gave community members a more active role in the health promotion. In Africa and in many parts of the world, self-care has been practiced in the homes despite the formalization of nursing by Florence Nightingale. The only problem is that, its efficacy had not been evaluated. The study attempts to determine the practices families perform to control fever. Adegoreye (1984) stated that the role of the mother in family health care is to take an intelligent interest in, and assume the responsibility for, monitoring and maintaining the health of her family, to recognize deviations early and give emergency life saving care for common childhood ailments such as fever, diarr⁶hea, vomiting and convulsions and bring the child as soon as possible for more specialized care.

However in order to conduct such practices, the homecare provider must make decisions which involve self-observation, symptoms and labelling, judgement of severity of the condition, choice and assessment of treatments and options. These indeed are features which the home care giver who brings a child aged 0-6 years to the health centre experiences and utilizes before bringing the child for further management.

Some of the practices are harmless and thus, they are useful in the control of fever. Mothers use both western and traditional methods to control fever. The reducing of fever by tepid sponging or cold

bath, reduced clothing and nursing the febrile child near an open window are methods based on scientific reasoning and are harmless if followed rationally. The use of herbs to induce perspiration and reduce fever are some of the most used practices, but their class is yet to be known since the claim of their safety is yet to be researched upon. The offering of specially made soups which offer extra fluids and nutrients to the sick child are such harmless practices which are practiced in some West African tribes of Nigeria (Adegoreye, 1984).

There are other practices which are the opposite of the foregoing; such ~~are~~ harmful practices like those of treating a child with convulsions by putting the child's feet near fire, or pouring cow's urine down the child's throat, in addition to the toxic effect of the cow's urine, it is often inhaledand the child dies of inhalation pneumonia.

In some other situation, the problem of performing certain practices were due to lack of understanding of underlying problems.

Brownlee(1978) reported of a culture in Orissa of India who took mosquitoes to be annoying but not harmful creatures. They based the cause of Malaria to be due to climatic changes during hot and cold weather and not the mosquitoes. This community felt malaria was a minor problem because fever went down by itself with time. Another common error but harmful practice is cited by Jolly (1976), which is the over heating of the sick child, having all bed-room windows closed in the false belief that if a child is feverish he must be kept warm. This mistake is often a factor in the production of febrile convulsions.

The use of a charcoal or coal burner to keep the nursing room of a febrile child warm is one other practice which leads to intoxication of the sick child with carbon monoxide from the coal or charcoal fire.

Adegoreye(1984) reported another harmful traditional practice in the control of fever. This is in relation to non-~~ac~~ceptance of isolation cases of fever due to infectious communicable disease. In the Yoruba culture of Nigeria, it is a taboo not to visit a relative who is sick, so isolation is violated on this basis. The belief is that infection causing the fever will seek out offending friends or relations and ~~as a~~ punishment will attack the non-visiting relation. Thus, to avoid this punishment they prefer to visit the sick person rather than keep away and suffer the punishment.

This is a harmful practice because it jeopardizes the health of the people, as such, it is one such practice which should be discouraged through health teaching.

One of the practices cited by King(1983) was that the people of Madura poured water over a child with a febrile fit. This is a good practice because a fit is often caused by high fever and water cools the child. However, one wonders whether the practice is based on the understanding of the causal and effect relationship of fever and febrile convulsion or it is just coincidental. Morley (1973) also observed that when dealing with home practices, there are some practices which are harmful practices such as subjecting children's feet to heat when they have a convulsion this would increase the fever and promote the convulsions.

Mercer (1983) experienced that whenever one is dealing with subcultures it is important to appreciate the culture of that given community because of the implications it has on the practice. Discussions with a few mothers revealed that there are varied practices on the management of fever which would be classified as harmful. Some of the Nsenga people vigorously sway the febrile child to shake off the fever(the "ill-wind"); but this action would increase the

heat production and therefore precipitate the convulsions.

Thomasma (1983) argued that parternalistic approach to health care delivery service has promoted dependency on conventional medicine which leads to newer harmful practices. In the case of controlling fever, it would mean giving aspirins whose knowledge on dosage may be minimal therefore, lethal.

Morley (1973) stated that harmless practices should be substituting the harmful self-care practices where applicable. The application of cool water to a child with convulsions would be useful to replace the heating of child's feet mentioned earlier on in the literature. When health workers identify the harmless and the harmful practices in the control of fever and they commend the home care providers on the activities they performed well; the home care providers would gain strength and get motivated to do more and achieve self-esteem which is the universal need for promotion of self-reliance and a key factor for continuing with self-care practices (Meisenghelder, 1985).

Werner (1982) reported on his observations made on the Makapawa community of the Philippines where he saw the mothers prepare a herbal cough syrup which cured many colds, coughs, stomach distress and many minor problems which would include fever. This particular preparation was a good harmless practice in that it involved men in the preparation of the syrup which was reported to be a low-cost home remedy. It also saved the women money on the costly trips they had to make to the centre for treatment and also the money they spent on the buying of medicine from the shops; this syrup was made from easily available herbs. The practice was more commended as the savings made were used to buy food for the children who would otherwise have gone hungry.

Home-care providers gain confidence in their practice especially when they are able to handle problems of control of fever to prevent febrile convulsions on their own. Litowinsky(1984) reported that the ability for home care providers to handle the problem on their own is a milestone which made parents who cared for their own children in the home confident. Herskowitz(1983) cited that attention to the management of the febrile child should be made because of the misconceptions about fever which caused anxiety in parents of such children. Some of these anxieties in the parents could be associated with what practices to keep and which ones to be stopped because of their harmful effect.

The practice of home control of fever to prevent febrile convulsions is not without problems. Levin(1981) cautioned that self-care should not mean transfers of professional responsibilities to laity or how that would happen. On the contrary, the health professionals had to carefully establish clinical practices, prevention, promotive and rehabilitative for their essential worth, they would establish technical criteria for selection of appropriate clinical skills for transfer. One such skill on self-care would be how to establish parameters on continuity of self-care and limits for unsafe self-care. Brownlee(1978) stated that the care a family member received in the home affected the members' health much more than any treatment received through formal health facility. Only with a knowledge of what happened at home can the health worker most effectively treat the patient in the facility. Therefore, the health worker should only support or complement the efforts of the home care providers.

In conclusion, there are self care practices on control of fever performed in the homes; some of these practices are harmless and will only be useful and advance if nurses and other health workers

collaborate or work in partnership with the home-care providers. This would enhance appreciation of each other's role. Selective approach on methods of discouraging the harmful practices would go a long way if the harmful practices were identified and the reasons for their being harmful was patiently explained to the home care provider, this would increase community co-operation. Hart(1977) observed that children and families need continuity in the whole range of primary care; they need a home care provider, a family nurse as much as they need a doctor only for specialized care and support. Given the know-how of self-supportive concepts of home care control of fever the home care providers would do everything to nurse a febrile child in the home.

CHAPTER 5

METHODOLOGY

1. Research Design

A correlation descriptive research design was chosen for the study. The reason for the choice was that the study was determining the home practices that constitute self-care. Chater (1975) postulates that correlation descriptive research design focuses on factual information, that is the data needed to answer the question or to test the hypotheses stated in the problem. The descriptive research design helped to look at the practices of self-care on the children with fever of age 0-6 years as a means of controlling the fever and preventing febrile convulsions. Seaman and Verhonick (1982) state that correlation descriptive designs are useful to examine the extent to which changes in one factor vary with changes in one or more other factors. The study looked at the activities which took place in homes before the home care providers brought the febrile children to the health centre for help. The study sought to find out whether those activities performed by the home care providers would form a base for ideas that would assist in the promotion of self-care which is the present means of health care delivery service.

Polit and Hungler (1981) state that correlational descriptive studies lead to practical application. The results of the study, it is hoped will be of practical use and can be incorporated in the health teaching of home care providers faced with a febrile child and being served by the Kabwata Health Centre of Lusaka.

2. Research Setting

The study was carried out at Kabwata Health Centre which is in Zone four (4) of Lusaka Urban. Mc Mahon et al (1980) describe a health centre as a place where a health team is based and from which health services are rendered to individuals and communities. Kabwata Health Centre was a Ministry of Health Centre up until December 1985 when it was handed over to the Lusaka Urban District Council.

It is situated within five (5) to ten (10) minutes walking distance from the University Teaching Hospital of Lusaka, Zambia. It serves a population of over 21,000 persons as estimated in clinic report. The catchment area for Kabwata Health centre is from third (3rd) phase of Libala, David Kaunda Compound, Kabwata Prisons' camp, Sikanze Camp, Ridgeway, Longacres, Kabwata site and service and Burma Residential area. The twenty-first (21) street forms a boundary of Kabwata Health centre with Libala stage one. The centre offers both curative and preventive services to its community. It operates from 07.30 hours to 16.00 hours Monday to Friday of the week. On Saturdays, the services are from 07.30 hours to 12 noon and on Sunday from 07.30 hours to 10.00 hours. After the stipulated hours, clients/patients walk to the University Teaching Hospital for services.

The personnel for the health centre are assigned to specific working areas, that is, there is a definite group for the curative section and another team for the preventive maternal and child health services. The staff working in the curative section comprise of one (1) Registered Nurse in charge of the

Health centre, four(4) General clinical officers, one (1) psychiatric clinical officer, six (6) Female Enrolled Nurses, one (1) Male enrolled nurse, three(3) clerks, one(1) Gardner and two(2) security guards. In addition, there is a medical officer who covers Kabwata and two (2) other Health centres in the Zone. Similarly, the public Health Nurse also covers four (4) other health centres in the Zone.

On the preventive Maternal and child health services, the staff comprise of (1) Public Health Nurse who is responsible for clinical teaching of student nurses gaining community health nursing experience, two (2) family health Nurses, two(2) Midwives and two (2) Nutritional Demonstrators. Lastly there are two (2) cleaners who keep the floors of the clinic clean and perform other non-nursing duties. The overall supervision for the running of the centre is in the hands of the Provincial Nursing Officer, whose office is at the Provincial Medical office of Lusaka, but with the latest change, the centre will be supervised from the civic centre- the head office of the Lusaka Urban District Council. The supplies came from the same office except for the vaccines, which even before the change over came from the Civic centre.

The estimated daily attendance of Kabwata Health Centre is between three hundred (300) to five hundred (500) persons. Kabwata has a telephone for communication with the referral centre; the University Teaching Hospital of Lusaka. Kabwata's proximity to the referral Hospital is of **great** advantage in dire emergencies like patients with complications of **uncontrolled** fever got there quickly for further management. The central location of this centre is also of great advantage to the community it serves.

3. SAMPLE SELECTION

Treece and Treece (1982) define sample as part of a whole.

The target population of the study were the adults who gave care to children with fever, aged 0-6 years in the home setting and they brought the children to the health centre for further management. Before selecting the sample, permission was sought verbally, followed by a written communication to the authorities of the Kabwata Health Centre as per letter (Appendix 1). A written permission was granted as per letter (Appendix 2).

The sample comprised of adults who gave care to children at home. These adults were of both sexes and had to be at least twenty (20) years of age and above. This was considered to be the appropriate age whereby the individual stood more chances of exposure to caring for children with fever. Both sexes were included because the study aimed at avoiding sex bias in the promotion of home care practices. The other criterion was that these adults had to have cared for a child with fever at home and this child had to be of age 0-6 years. The age of the child was confined to 0-6 years because observations and experience showed that this age group was the one frequenting the health centre most. The age above six (6) years was going to school and their problems were slightly different; the school health team would take the initial care for the school going child with fever in such situation and the parents would only continue with the initiated care. Therefore, the study was confined to the care the home care providers initiated. The other criterion for the subjects to be included in the study was that, the child they brought to the health centre had fever. This was an

important criterion because subjects would easily remember what they did to reduce the fever since the problem is still there. Lastly, these adults who brought the febrile children to the clinic were to be attending Kabwata clinic at the time of data collection; this was to allow the study result to fit the described setting. Though it was desirable to select the sample randomly, that is giving each subject in the population an equal independent chance of being selected a sample of availability was taken. This included any sixty (60) adults who reported to Kabwata Health Centre with a child aged 0-6 years with history of fever or "body hotness". This was purposeful sampling which means using readily available, convenient group of subjects manageable in the given time for the study.

4. PILOT STUDY

A pilot study is defined by Sweeney and Olivieri (1981) as a conduction of a small scale study that include an analysis of results. The pilot study is used to refine the researcher's overall design. This study is a pilot study in itself because the sample is not large enough to make any generalizations. In addition to this, a study of this kind has not been done before in this country, this study can be considered as a pilot study in itself. The other reason for not carrying out a pilot study is the time limit within which the study had to be submitted to the Department of the Post Basic Nursing, University of Zambia in Lusaka. Since a pilot study helps to ensure content validity for the instrument being used. (Sheenhan, 1985), the tool for collecting data for the study was checked by peers, and the supervisor for clarity, objectivity and reliability.

5. TOOL FOR DATA COLLECTION

The tool of choice for collecting data for the study was a

Structured Interview Schedule (Appendix 3).

The structured interview schedule was chosen because it was planned in detail in an attempt to standardise the questions as much as possible. The literacy of the respondents was not known, so the interview schedule allowed the inclusion of illiterate subjects. There was direct contact with the respondents, and an opportunity to clarify questions and thus, giving more chance for all questions to be answered. There was opportunity to get first hand information from home care providers on their home self-care practices on fever control. More closed questions were preferred, to make it easier to collect material which was easily processed and coded within the time limit.

However, there are many disadvantages which one faces when using an interview schedule as a tool for collecting data; the main one being, the long time it takes to design it; the long time it takes to interview all the subjects in a specified time but with proper guidance, perseverance and proper scheduling of time, this was overcome in the study. Treece and Treece (1982) state some of these disadvantages as; responses may be only opinions, but for the study the questions specifically asked for the activities the home care providers performed, therefore this was not a problem. The other disadvantage is that subjects may not be able to recall, this disadvantage was overcome by asking the subjects the activities which they carried out on the current diagnosis of fever. The next disadvantage is that, the respondents may seek the approval of the interviewer, in the study this was overcome by explaining to the respondents that they had to give an account of the activities they carried out before they brought the children for further management of fever and they were put in a position to do this because they were more knowledgeable on those actions as opposed to the interviewer who was not there. The other identified problem of

interviewing is that not everyone is willing to be interviewed, this was not the case with the respondents of the study, they gave information willingly. The other disadvantage is that the respondents may be nervous because of the answers being recorded. This was overcome in the study by assuring the respondents of anonymity and confidentiality; the purpose of the study was explained to each of the subjects and each was told how the information obtained was going to be used to benefit him/her and his/her friends who may not have similar knowledge and skills and would learn from their experiences. This appeared to motivate and encourage the respondents of the study.

The question sequence in the tool was organised in this order. Questions one (1) to ten (10) asked on demographic data; question eleven (11) asked for the duration of the fever as a parameter for determining the termination of self-care practice. Questions twelve (12) to twenty-three (23) elicited the self-care activities respondents performed and their rationale. Questions twenty-four (24) to twenty-six (26) requested for the home care providers' suggestions on self-care practices needing health teaching and possible venue and avenue for learning the practices. After making a test run on peers, to make modifications and alteration found necessary in the absence of a pilot study mentioned earlier, the tool was ready for use on the sample by second week of February 1986.

DATA COLLECTION

When the Provincial Nursing Officer of the Lusaka Province granted a written permission (Appendix 2) and as soon as the data collecting instrument was completed in the second week of February 1986, data collection started. The Kabwata Health Centre personnel were informed of the intentions of the study. The sister-in-charge of the health centre who had already been informed about the study was very supportive. She offered a room to ensure privacy for the clients despite the existing problems of space in this health centre. The home-care providers were referred to the data collecting room by the clinical officer(s) who took the temperature of the child and based the selection on the age of the health care provider, that is if a child was brought in by another child they were not included in the sample. The selection was also based on the age 0-6 years and the diagnosis of fever as "body hotness" by the home care providers.

The care providers were told why the interview was necessary; to learn from them what actions they took when they discovered that the child had fever. This information was needed to share it with others who would be faced with a similar situation; and sharing would be through health teaching. After gaining their co-operation, they all gave information willingly. More patients were interviewed on Saturdays and Sundays than during the week day because there was a high turn up of clients with febrile children.

The high turn up of the clients with febrile children was associated with the fact that the health centre staff were only providing the services in the mornings. On Saturdays up to twelve-thirty (12.30 hours) and on Sundays up to ten (10) hours only. After

interviewing the home care providers they were offered opportunity to ask questions and it served as a feed back mechanism to ease their queries if they had any. They were lastly thanked for their time.

The most satisfying aspect was respondent's willingness to cooperate. The health centre staff showed their cooperation and support too; which was demonstrated by their interest that no possible subject was to be missed and also by enquiring on the progress made on the interview.

In conclusion, data collection posed less problems than anticipated, there was only one time that an interpreter was necessary from Bemba to English for a home care provider who could not communicate in Nyanja and a willing health centre personnel did this effectively.

CHAPTER 6

DATA ANALYSIS AND PRESENTATION OF FINDINGS

1. DATA ANALYSIS

The study sought to determine the self-care practices which home care providers performed on the febrile child in the home before seeking assistance from Kabwata Health Centre of Lusaka Urban in Zambia. The data for the study were analysed manually with the aid of a pocket calculator. Hunt (1984) explains that data analysis is the grouping, classifying, coding and counting as well as carrying out statistical analysis where appropriate on the data collected. It also includes the documentation of information into tables, graphs, and barcharts. The responses collected through an interview schedule were tallied by a method of tallying four(4) strokes crossed with the fifth(5) horizontal stroke(||||).

The descriptive statistic analysis was used to process and categorise the data. The averages were computed to give the responses a measurement and a summary (Polit and Hungler, 1983). The results of the computation were rounded to whole numbers since the study is dealing with discrete scales of measurement used for finite population. The findings are summarized in tables; they are outlined in an order of what is practiced most in order to reflect the commonalities or similarities of home practices. Chater (1975) says that tables are helpful to summarize data from which relationship between variables can be seen. The tables in the study are intended to accomplish this fact.

2. FINDINGS:

TABLE 1: AGE AND SEX DISTRIBUTION OF RESPONDENTS

AGE RANGE	NUMBER OF RESPONDENTS	PERCENTAGE	SEX	NUMBER OF RESPONDENTS	PERCENTAGE
20 - 29	33	55	Female	56	93
30 - 39	25	42			
40 - 49	2	3		4	7
TOTAL	60	100	Total	60	100

TABLE 2: MARITAL STATUS OF RESPONDENTS

STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Married	49	82
Single	8	13
Divorced	3	5
TOTAL	60	100

TABLE 3: RESPONDENTS' OCCUPATIONS

OCCUPATIONS	NUMBER OF RESPONDENTS	PERCENTAGE
Housewife	27	45
Dependant	8	13
Secretary/Typist	7	12
Banker/Financial Clerks	5	9
Other	4	6
Nurse	2	3
Teacher	2	3
Marketeer	2	3
Policeman	2	3
Nanny	1	2
TOTAL	60	100

TABLE 4: RESPONDENTS' RESIDENTIAL AREAS

RESIDENCE	NUMBER OF RESPONDENTS	PERCENTAGE
Within Kabwata Health Centre Catchment Area	58	97
Outside Kabwata Health Centre Catchment Area	2	3
TOTAL	60	100

TABLE 5: RESPONDENTS' EDUCATIONAL ATTAINMENT

EDUCATION ATTAINED	NUMBER OF RESPONDENTS	PERCENTAGE
High School	31	52
Primary	16	27
Junior Secondary	6	10
College	4	6
No Education	3	5
TOTAL	60	100

TABLE 6: NUMBER OF CHILDREN RESPONDENTS HAD

NUMBER OF CHILDREN	NUMBER OF RESPONDENTS	PERCENTAGE
1 - 3	26	44
4 - 6	20	33
None	8	13
7 - 9	5	8
10 - and above	1	2
TOTAL	60	100

TABLE 7: RESPONDENTS' RELATION TO THE FEBRILE CHILD

RELATIONSHIP	NUMBER OF RESPONDENTS	PERCENTAGE
Parent: Mother/Father	51	85
Nephew/Niece	6	10
Other	3	5
TOTAL	60	100

TABLE 8: AGE RANGE OF CHILDREN WITH FEVER

AGE RANGE	NUMBER OF CHILDREN	PERCENTAGE
1 - 3 years	26	43
Under 1 year	19	31
4 - 6 years	16	26
TOTAL	61	100

Although the sample constituted sixty(60) respondents, there are sixty-one (61) children because subject number four(4) brought two(2) children with fever and they were aged below six (6) years.

TABLE 9: Number of respondents who took action to control fever at home

ACTION	NUMBER OF RESPONDENTS	PERCENTAGE
Took action	52	87
No action	8	13
TOTAL	60	100

TABLE 10: What respondents thought were the causes of the fever

CAUSES	NUMBER OF RESPONSES	PERCENTAGE
Malaria	20	30
Infections	18	27
Coughs and Colds	18	27
Teething	4	6
Do not know	3	5
Other	3	5
TOTAL	66	100

TABLE 11: Maximum number of days respondents took before termination of self-care on the febrile child

RANGE OF DAYS	NUMBER OF RESPONDENTS	PERCENTAGE
1 - 3 days	49	82
4 - 7 days	9	15
8 - 11 "	2	3
TOTAL	60	100

TABLE 12: Reasons respondents gave for termination of self-care on the
ON THE FEBRILE CHILD

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
Wanted to seek professional care	22	37
Lack of response to treatment given	20	33
Seeking assurance of correct care	10	17
To get Investigations done	8	13
TOTAL	60	100

TABLE 13: Activities respondents performed to control fever on the febrile
CHILD AT HOME

ACTIVITY	NUMBER OF RESPONSES	PERCENTAGE
Administered Medicine	44	70
Did nothing	8	13
Cooled child's body	7	11
Dressed child's warmly	2	3
Gave child cold drinks	2	3
TOTAL	63	100

TABLE 14: Name of medicines respondents administered to control fever
at home

NAME OF MEDICINE	NUMBER OF RESPONDENTS	PERCENTAGE
Cafenol	13	22
Aspirin	11	18
Name not known	11	18
No medicine given	8	13
Panadol	7	12
Chloroquine	7	12
Other	3	5
TOTAL	60	100

TABLE 15: Source of medicines given to children for control of fever

SOURCE	NUMBER OF RESPONDENTS	PERCENTAGE
Left overs from previous prescription	22	37
Bought the medicine	19	31
Did not give medicine	16	27
Other	3	5
TOTAL	60	100

TABLE 16: How respondents administered the medicine

INSTRUCTED BY	NUMBER OF RESPONDENTS	PERCENTAGE
Nurse/Doctor/Chemist	20	33
Self-instructed	19	32
Did not give medicine	16	27
Read instructions on the packet	3	5
Other	2	3
TOTAL	60	100

TABLE 17: Number of respondents with past experience in handling of CHILDREN WITH FEBRILE CONVULSIONS

EXPERIENCE	NUMBER OF RESPONDENTS	PERCENTAGE
Has Experience	32	53
No Experience	28	47
TOTAL	60	100

TABLE 18: Respondents suggestions on what to do when caring of a febrile Child

SUGGESTIONS	NUMBER OF RESPONSES	PERCENTAGE
Take child to clinic	22	29
Cool child with cold water	22	29
Give medicine	19	25
Use traditional herbs	6	7
Give warm bath/dress child warmly	3	4
Give cold drinks	2	3
Other	2	3
TOTAL	76	100

TABLE 19: Number of respondents who would like to be taught how TO CARE FOR CHILDREN WITH FEVER AT HOME

PREFERENCE	NUMBER OF RESPONDENTS	PERCENTAGE
Like to learn	59	98
Do not like to learn	1	2
TOTAL	60	100

TABLE 20: Places suggested by respondents for learning the care of a febrile child at home

VENUE	NUMBER OF RESPONSES	PERCENTAGE
Health Centre	32	46
Welfare Centre	13	19
Recreational Place	11	16
Own Home	10	15
Other	3	4
TOTAL	69	100

CHAPTER 7

DISCUSSION OF FINDINGS, PRACTICAL NURSING IMPLICATIONS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

1. Discussion of Findings

The aim of the study was to determine the self-care practices employed by home care providers to nurse the child with fever in order to prevent febrile convulsions occurring as a result of high fever. The sample consisted of sixty (60) adults who brought febrile children to Kabwata Health Centre for further management of controlling fever. Table 1 P. 31 presents the age and sex distribution of the respondents referred to in the study as home care providers. The majority (93 Percent) were female home care providers. Only 7 percent males brought the children to the health centre out of the sixty (60) subjects. This may be attributed to the fact that the caring of sick members in the home is mainly the function of the female members of the family. In contrast the male home care providers brought children to the health centre because they were relieving their female counter-parts who were either away on some errands or not "feeling well" for example being in late pregnancy. It was noted that adults in the age group below forty (40) years were in the majority (97 percent) of the home care providers who brought the children to the health centre, probably because this is the pick age group when mothers learn the experiences in child rearing practices.

Orem (1980) affirms that practices of self care are a continuous life long process, and for one to continue with self-care practices it is necessary to understand the practices

prepared them on the chores of home management practices which included child care of the febrile child.

Table 4 P.³²..... indicated that the majority (97 percent) of the respondents lived within the Kabwata Catchment area though (5 percent) of these were visitors from the rural areas. Their inclusion in the study was of significance because their practices were slightly different from those of the Urban dwellers, They mentioned practices and beliefs which included avoidance of sexual relationship whilst the child had fever, shaking off the "ill wind" from the febrile child at the cross roads and seeking help from the traditional healers, but what was not elaborated upon was how these practices worked. In this era of scarce resources, it is wise to explore some of these latent traditional possibilities. Osuntokun (1985) says that it would be misleading not to recognize that many of the African traditional beliefs and medical practices have significant implications for national health policies. What is needed is to control and regulate the practices because traditional healers presumably do a lot of good in some areas. The remaining three (3) percent of the respondents lived in Lusaka but outside the Kabwata Health Centre catchment area. Their reasons for utilizing Kabwata Health Centre were outside the context of the study, as such they were not solicited.

The educational attainment is tabulated in table 5 P.³².....the findings of the study revealed that the highest attained level of education was high school (52 percent) and those who did not have formal education were (5 percent). From the discussions with the respondents, it was established that the level of education made no significant difference on the decisions home care providers made to practice self-care. They practiced self-care regardless of their educational attainment; they either gave Medication to the febrile

child or took no action other than that of taking the child to the clinic. Respondents were helpless when they were faced with a febrile child despite their educational attainment; therefore hypothesis number 2 which stated that home care providers who have formal education practice more self-care in the home before seeking help from the health institution is rejected. Similarly, Casey (1984) found that the parents of his study demonstrated helplessness in the management of fever at home despite relatively high education.

Most home care providers had children of their own (table 6P.....³²) with an average family of (1-3) children. This is an indication of a large population which is susceptible to fever, a prevailing childhood problem in many families. Thus it would become necessary to find out more of the practical solutions to this problem.

Table 7 P.....³².....illustrates the relationship of the respondents to the febrile child. The majority (85 percent) of the study group were parents of the febrile child. These findings signified the importance families particularly mothers placed on the care of their sick relative like the febrile child. Brownlee (1978) avers that in communities where children are valued, the health workers would be successful if they emphasized the practices for achieving the well being of any other family member through a child because the child is the centre of attention in a culture who value children. The community of Kabwata valued children because most mothers (85 percent) left the other duties and brought the febrile child personally to the centre for further management of the sick child. The age range of children who were presented to the health centre for further management of fever control is shown in table 8P...³³..... There were sixty-one (61) children instead of sixty (60) children because one mother brought two children who met the age criterion

for inclusion in the study. The significance of this age range is that it depicts the at risk age group for febrile convulsions. Freeman (1980) observed in his study that vulnerable age group for the likelihood of febrile seizure to occur is 3 months to 5 years because it is usually associated with fever. In the study it was observed that fever was commonest in children aged 1-3 years. This is the age group which is also prone to infections, malnutrition and other enteric diseases. Therefore proper management of fever in these children would be one way of reducing some of the ailments this age group is subjected to.

The study's findings revealed that home care providers practiced self-care before they sought further management of a febrile child from the Kabwata Health Centre (table 9P.33). The self-care practices were associated to some diagnosis they made (table 10 P 33). It was noted that most respondents relate fever to some illness; the home care providers based the administration of medicines they gave to the febrile child upon the diagnosis they had made at home. However, they were not able to identify the care skills they used to comfort the child basing the care on the same diagnosis. For example 30 percent of the respondents associated fever with malaria, they were able to give the febrile child anti malarial medicine available; yet they were unable to describe the activities they performed to assist the febrile child to be comfortable from the symptoms of the malaria.

The foregoing clients' practices are similar to what is going on in nursing practice, today, nurses would administer medications prescribed by physicians for the malaria but not all nurses would state and record the nursing care they carried out on the febrile child to relieve him/her from the discomforts generated by the malaria.

These trends would need to change since nurses are role models for the clients who are the primary cadre of giving care in the homes. The present situation which clients had adopted would be alluded to the fact that clients are copying from the nurses; drug administration is interpreted to be synonymous with nursing and yet it is only part of it. Since clients trust and model nursing personnel on health matters, nurses should maximize this opportunity to implement meaningful practices which would benefit effective implementation of primary health care.

Table 11 P.³³..... showed the maximum number of days respondents took before they terminated the self-care practices. Important in the self-care practices is the need to determine the parameters for continuity or termination of self-care. In the study most of the home care providers (82 percent) terminated self-care on fever which went beyond three (3) days. They also terminated care to seek professional care when the child did not respond to the treatment they gave. Some home care providers terminated self-care when the child's condition worsened and others did so in order to seek assurance of correct care (table 12P.³⁴.....). Orem (1980) states that parameters are a means of determining how to stop self-care practices when need arose. Such factors could be the internal factors, for example, the inexperience of the individual, family and community or the external factors, for example lack of resources for the practice, The home care providers of the study practiced self-care on control of fever on the febrile child in the home. They had indicators for stopping the practices when they realized their limitations of not being able to cope with the practices in the home. Therefore hypothesis number 1 which stated that knowledge of parameters for decision making on self-care assist home care providers to continue with self care or seek outside help is

accepted.

On the contrary, hypothesis number 3 which stated that lack of parameters for decision- making make continuity of self-care unsafe is rejected because the home care providers stated valid parameters on which they based the termination of self care. Orem (1980) states that lack of skills in task performance, failure to validate judgement or inability to make judgement would adversely affect the accomplishment of self-care. The experience of the respondents of the Kabwata Health Centre was such that they did not continue with self-care practices when they lacked the skills to be used in the control of fever in a febrile child at home.

The home care providers carried out a variety of practices to control fever on a febrile child (table 13 P...³⁴.....). Top on the list of the activities performed to control the fever were the responses of those who gave medicine to the febrile child, they accounted for 70 percent of the respondents. The names of the most preferred medicines are shown in table 14P...³⁴.....and the sources from which they obtained the medication and instructions for administration of these medicines are illustrated in tables 15P...³⁴.....and table 16P..... respectively. There was a preference for children's cafenol to be the most favoured antipyretic as indicated by 22 percent of the reponses. This could be due to the fact that it is readily available in the shops for mothers. The second favoured medicine was aspirin whose source was left overs from previous prescriptions (37 percent) for other illnesses. The respondents sought assistance from professionals for dosage they had to administer to the child. It was shown that 32 percent were able to comfortably give the medicines on their own self instruction. This determines the home care providers potential for giving self-care. Although

it is recognized that home care providers practice some care in the control of fever, the findings in the study did not give adequate information to back the hypothesis number 5 which stated that home care practices of controlling fever in children aged 0-6 years indicate safe self-care. The hypothesis is then neither accepted nor rejected because some practices may be safe and others may not be.

However, it was observed with concern that the home care providers used left over antibiotics from previous prescriptions. This was a harmful practice since it subjected the febrile child to under treatment and would result in the child getting subtherapeutic doses and resistance. Okeahialam (1982) states that a child with fever or cough would be given subtherapeutic doses of ampicillin syrup which would lead to the diagnosis of partially treated meningitis a complication which would lead to resistance of the common causative organisms in the environment. The same applies to the respondents who administered left over medicines some of which could have expired resulting in no improvement in the child's condition. Sometimes, the expired medicine may be poisonous to the child. Although the practice of giving an aspirin to a febrile child is good, it can be harmful when home care providers are not knowledgeable on expired medicines. Thus, hypothesis number 4 which stated that some of the home practices on the control of fever are harmful and render self-care unsafe is accepted. Other harmful events which would emanate from these practices are the home accidents of drug poisoning in the children. The home care providers seemed unfamiliar with side effects which would arise from these practices. This was demonstrated by their eagerness to learn more about the need to care for the febrile child in the home (98 percent) illustrated in table 20 P.³⁶.....This need for learning is important.

Christ, (1983) emphasises that health care must begin outside the hospital.

Olusanya(1981) advises that health personnel should make the clients aware of the dangers of excessive use of medicines. In the case of Kabwata Health Centre users, the topics of choice on this subject area would include the side effects and contra-indications in the use of cafenol, aspirin and traditional herbs in the control of fever in the febrile child in the home. Prevention of poisoning from these listed drugs would also be included.

The other practices which the home care providers applied to control fevers in the home are presented in table 13.234... where by respondents made reference to the use of practical activities like cooling the child's body with cold water. Cooling with cold water is the process which nurses use in the hospitals as tepid sponging. If it is done properly this practice is useful and versatile to both the urban and rural persons. Done (1972) states that tepid sponging, when cautiously performed is probably the safest method available for reducing febrile temperature.

From the study some respondents felt they had inadequate knowledge on the procedure of this practice; one respondent said " I use water from the fridge to cool the child's body when it is hot". Another said "I have not experienced fits because I sponge the child's body but the problem I face is that of the children catching colds and coughs which do not respond to the cough mixtures I buy for them" This could be associated with the problem of exposure of children during this procedure. Edge (1971) cautions that when performing tepid sponging to reduce temperature, care should be taken not to let the child get chilled or overtired by too much handling movement. The results of the coughs and colds in the febrile child

after having had tepid sponging could be the results of the child being subjected to exposure and overhandling by the home care provider during the procedure.

The buying of medicine also does not solve the cost elements of health delivery services which means when one has no money the febrile child would not be alleviated from the symptoms she/he is presenting. This defeats the whole purpose of primary health care to become a reality. Then it should be a primary concern to establish practical means of dealing with fever; these practical means should be developed implemented and encouraged. Only 3 percent of the respondents gave cool drinks to the febrile children as opposed to 70 percent table 13.P...34.....who gave medicines. One wonders what happens in the remote areas of the country where neither cafenol nor left over medicines are readily available. The use of these other simple but practical methods of controlling fever in the home on a febrile child need to be devised and implemented. Table 17P...35..... indicates respondents' past experiences on the care of a febrile child. Over 50 percent of the respondents had experienced the crisis of a convulsing child. This calls for the need to prepare the home care providers to meet this crisis. The preparation of the home care providers on management of this crisis should be the prerogative of health workers within the primary health care context. Some respondents admitted to have overheated the febrile child, this of course increased the fever and gave them the midnight runs to the hospital in the absence of the best practical alternative to undertake. The nurses must take the challenge to share their knowledge with this emerging cadre of personnel-the home care provider. It has to be appreciated that the home care provider need to be properly equipped for the febrile crisis from the uncontrolled fever because she is the permanent person to deal

with this problem in the many homes. In the long run it would be the most feasible cheap alternative method of health care delivery service.

The home care providers suggested ways of dealing with the febrile child in the home (table 18P...³⁵):...These included taking the child to the clinic 29 percent, using tepid sponging 29 percent, giving medicine 25 percent, using herbal traditional herbs 7 percent and warming the child by 4 percent and only 3 percent gave the child cold drinks. The significance of these findings are that the home care providers do have faith and trust in their clinic/health centre. They performed tepid sponging though their procedures were incorrect and necessitated them to learn. Only 7 percent of the respondents in an urban health centre suggested traditional use of herbs, this could be due to their orientation and upbringing in the inner cities; maybe the situation would be different if the study was carried out in the rural area. The clients who gave fluids to the febrile child were only 3 percent and this was due to their orientation as mothers and nurses; yet it is one such practical method which could be taught to the home care providers.

Teaching of the home care providers on the management of a febrile child at home is long over due; the majority 98 percent indicated they wanted to learn correct procedures on the care of a febrile child. Table 19 P...³⁵.....shows an indication of this. They also willingly suggested venues for where this learning could take place table 20P...³⁶.....These places started with the health centre, the welfare centre, the recreational hall and their own homes. The most favoured places was the health/centre 46 percent of the responses. Thus reaffirms the fact that a health centre is a gate way to and from community.

In conclusion, the findings revealed that home care providers of Kabwata practice selfcare at home to control fever in a febrile child. Their practices were however, influenced by urbanization. Their practices concentrated on administration of medicines based on the diagnosis they associated the fever with. Other practical means of relieving fever in the febrile child were limited by inadequate knowledge, skills and practices possessed by the home care providers. Therefore, there was need for nurses to assist the home care providers to improve on these skills. It had been assumed for a long time that communities are passive recipients of care but clients are willing to change if nurses recognize to use the challenge posed by the strategy of primary health care which requires them to work in partnership with the home care providers so that safe self-care practices are encouraged and the harmful practices are discouraged for the individuals, families and communities.

NURSING IMPLICATIONS

The study has reaffirmed the women's traditional role of caring for the family members. Therefore, health workers in general and nurses in particular should build on the skills and knowledge to aid their primary health care function in the health care delivery systems. The practices which home care providers carried out were influenced by their environmental setting, therefore nurses should first determine the practices the community used so that meaningful or realistic procedures are set out and implemented; such as those needed for relief of ailments like fever. Most home care providers had experience on self-care practices. Therefore nurses should base their teaching on what the home care providers already know. Some of the home care providers did not take action for control of

fever at home as a result of not knowing what to do, this implies nurses should teach home care providers the practical skills of how to handle the febrile child at home.

Some home care providers expressed the need to learn the procedures of cooling the febrile child's body correctly; the nurses should explore and utilize this opportunity to teach them using some of their suggestions given in the study on what they would like to learn.

The reasons given by respondents as to why they brought a febrile child to the centre demonstrated the value the community have on professional nursing. Unfortunately, this is being viewed to be synonymous with the giving of medicines. Nurses should teach the community that giving medicine is only part of nursing practice. Giving comfort to the febrile child is one practical procedure which they could afford and handle well if they learnt the basis for doing it. Most home care providers gave medications for the fever they handled, this posed potential problems of underdosage, overdosage and drug poisoning leading to death. Nurses should take the obligation of explaining to clients the dangers of giving medications to the febrile child. Clients used the drugs excessively and at random. Nurses should teach clients to use medicines sparingly and with caution. Clients demonstrated willingness to learn from the nurse; the nurse too should encourage the client to do more for herself; such as giving cold fluids to the febrile child. The study revealed that although the home care providers practiced self-care, they lacked confidence and were uncertain of some practical procedures. This implied that nurses should demonstrate to the home care providers the correct procedures so that they learn and get encouragement on what to do when they are faced with a febrile child in the home.

It is hoped that the information of these findings will be utilized

in the teaching of home care providers and other cadres of health personnel through basic nursing education and in-service programmes. Nurses should view the care of minor ailments like fever as a means of assisting individuals, families and communities to reduce dependency on nurses and promote the clients responsibilities for self care.

In conclusion, the determination of self-care practices at Kabwata Health Centre has formed a foundation upon which to base the services according to the needs of the community. This promotes community participation for effective implementation of self-care. In turn, the achievement of the goal of health for all by the year two thousand (2,000) would be a reality to the client, community, nation as well as the international community at a larger scale.

3. CONCLUSIONS

The findings of the study revealed that self-care practices are carried out in the Kabwata community. The practices, however are influenced by the effects of social change on the environments. The home care providers did not come out with the typical traditional practices; the situation would probably be different if the study took place in the traditional rural area. The identified practices were overusage of medication which poses dangers of possible home drug poisoning if they were not kept properly. The other methods of relieving fever discomforts were not effectively implemented because clients were not knowledgeable on the procedures. The study determined that home care providers had a way of determining the continuity of self-care or its termination, this indeed rendered it safe and ruled out the assumptions that self-care practitioners lack parameters for making their practices safe. It has been established that parameters do exist but they are not in written form. There

is need to develop other means of relieving fever from a febrile child at home, that is something other than administration of medications and its effects.

RECOMMENDATIONS

1. Personnel of the Kabwata Health Centre should work in partnership with their community so that the concept of primary health care is intensified and the community is fully involved in their own care.
2. A study of this kind should be conducted on a large scale to enlist more of the practices and make generalizations.
3. Health Centre personnel should include topics on the care of a febrile child at home when they are discussing child care matters in the welfare meetings.
4. Demonstrations on correct procedures of controlling fever in febrile children should be done by nurses of the centre so that home-care providers are equipped with adequate skills on dealing with the crises of febrile convulsions.
5. Home visits should be used as a forum for identification of febrile children in the homes and followed up by practical demonstrations on how the fever could be reduced.
6. Clients utilizing Kabwata Health Centre should be provided with a suggestion box in which they put their learning needs on the care of a febrile child or any other topic of concern. Nurses should emphasize to clients the importance of completing the prescribed course of medicine so as to avoid the dangers of using the expired medicines to the sick members of family.
7. Community Health Nurses and Family Health Nurses should conduct a small study on how to give care to a febrile child in the home without the use of medicine.
8. A comparative study between the urban and rural practices on the care of a febrile child should be conducted by public health nurses so that the safe practices are encouraged and the harmful practices are discouraged as it applies to the given setting.

LIMITATIONS OF THE STUDY

1. There was limited local literature on child rearing practices which made it difficult to relate and compare them to the findings of the study.
2. There was limited time in which data had to be collected and the study completed for submission to the school of medicine, Department of Post Basic Nursing of the University of Zambia. This influenced the small sample in order to collect data

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which had to be analysed within the stipulated time.

3. Another limitation of the study was the use of a sample of availability in the absence of complete, correct **concise** records on the health care activities performed by the nursing personnel at the health centre. This was a limitation because the results from a sample of availability tend to have reduced objectivity, reliability and validity of the findings.
4. The sample was small, therefore findings could not be generalized.
5. The use of relatively untested instrument for collecting data was a limitation in that the findings would have been more accurate if the changes on the tool were made after carrying out a pilot study on a sample drawn from the actual population of the study.

APPENDIX 1

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O.Box 50110
LUSAKA

The Provincial Nursing Officer
P.O.Box 5001
LUSAKA

8th January, 1986

Dear Madam,

RE: RESEARCH STUDY

I am ^astudent at ^{the}University of Zambia in the Post-Basic Nursing department. I am required to submit a research study as part of the course requirements for the Bachelor of Science in Nursing degree. My area of interest is community nursing.

I would be grateful if you could kindly permit me to interview 60 adults who bring children aged 0-6 years to the Kabwata clinic so that I could determine the home care the children got in relation to the control of fever. I intend to collect data in February, 1986. Thanking you in advance for your assistance.

L. J. M. Chapuma (Mrs)

c.c. Provincial Medical officer
P.O.Box 5001
LUSAKA



APPENDIX 2

Office of the Provincial Medical Officer
Lusaka Province
P.O.Box 37136
LUSAKA

Mrs. L. J. M. Chapuma
The University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O.Box 50110
LUSAKA

13th January, 1986

RE: RESEARCH STUDY

I refer to your letter dated 8th January, 1986 on research study.

I am pleased to inform you that you can go ahead utilising Kabwata Urban Health Centre for the research entitled "Home Care Children get in relation to the control of fever".

Wishing you well in your study.

Thank you.

Signed

for/Provincial Medical Officer
LUSAKA PROVINCE

c.c. P. H. N. (KABWATA)

c.c. In-Charge Kabwata Health Centre

APPENDIX 3

- 1 -

INTERVIEW SCHEDULE

FOR OFFICE USE ONLY

NUMBER

--	--

1

--

1. SEX: Male_____ Female_____

2. How old are you?

1. 20-29

2. 30-39

3. 40-49

4. 50-59

5. 60-69

6. do not know

2

--

3. What is your marital status?

1. Married

2. Single

3. Widow/Widower

4. Separated

5. Divorced

3

--

4. In which part of Lusaka do you live?

4

--

5. Did you have chance to go to school?

1. Yes

2. No

5

--

6. How far did you go in your education?

1. Primary
2. Junior secondary
3. High school
4. College
5. University
6. Other (specify)

6

--

7. What do you do for your living?

7

--

8. How many children do you have?

1. None
2. 1-3
3. 4-6
4. 7-9
5. 10 and above

8

--

9. How are you related to this child?

9

--

10. How old is the child?

1. Under 1 year
2. 1-3 years
3. 4-6 years

10

--

11. For how long has the child had the fever?

1. 1-3 days
2. 4-7 days
3. 8-11 days
4. 12-15 days
5. 16 days and above

11

--

12. What do you think caused the fever?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

12

13
14
15
16
17

13. Did you do anything to control the fever at home?

1. Yes
2. No

18

--

14. What did you do?

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

19

20
21
22
23
24
25
26
27
28

15. Did you give the child any medicine for the fever?

1. Yes
2. No

29

--

16. What is the name of the medicine you gave the child?

30

--

25. Do you think it is ^a good idea that
parents share knowledge regarding
fever in children?

1. Yes

2. No

45

--

26. Where do you think is the best place
for sharing knowledge on control of
fever in the home?

1.

2.

3.

4.

5.

46

47

48

49

50

THANK YOU FOR YOUR TIME.

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