

MOTHERS' TRADITIONAL CUSTOMS AND BELIEFS
REGARDING DIARRHOEA IN CHILDREN WHO ARE
ADMITTED TO UNIVERSITY TEACHING HOSPITAL

BY

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DECLARATION

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

Signed..........

CANDIDATE

Approved by..........

SUPERVISING LECTURER

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly indicated in the text and in the references.

Signed: 

DEDICATION

Dedicated to my husband for his patience, encouragement and guidance and to my parents, other relatives and friends for their support and encouragement throughout the training.

ABSTRACT

The study was conducted at the University Teaching Hospital. It aimed at determining the mothers' traditional customs and beliefs regarding diarrhoea in children and the parameters they use in deciding whether to bring the children to the hospital or not.

Literature review was based on traditional customs and beliefs regarding causes and treatment of diarrhoea in Zambia and other countries and on child rearing practices. Observation and experience have shown that despite modern treatment and health education emphasis on prevention and control of diarrhoea, the morbidity and mortality rates of diarrhoea in children admitted to University Teaching Hospital has not declined. This has an economic constraint on the family and nation as a whole.

The study is descriptive in nature. Data were collected by interviewing forty (40) Zambian mothers whose children were aged between six (6) to twenty-four (24) months and were admitted to University Teaching Hospital.

The findings revealed that most mothers both young and old had a good understanding of what diarrhoea is and they know some form of traditional customs and beliefs related to causes of the condition in children. Most mothers gave their children some traditional medicine before they brought them to the hospital and most of them knew how this medicine was prepared and its effect on diarrhoea.

The findings further revealed that most mothers go to the neighbours, private doctor, their own mothers or to the traditional healer first when their children have diarrhoea. Most mothers said they brought their children to the hospital when the condition did not improve after administering other medicines

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(tradition or modern) or when they were referred from the clinic. This results in delay in bringing the children to the hospital for prompt, effective and efficient treatment.

Most of the information obtained makes the study important to the health personnel, therefore suggested readings are indicated in the bibliography. It is hoped the findings will provide the health personnel with an insight into the inadequancies of the present prevention, control and treatment of diarrhoeal programmes. Hopefully this can make the programme more appropriate, effective and acceptable to the clientele.

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I further thank the Acting Nursing Officer of Paediatrics, the nurses who worked in Ward A06 during the period of my study and the mothers whose children were admitted to Ward A06 and agreed to be interviewed, upon which this study is based and without whose cooperation this study would not have been possible.

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CHAPTER 1

INTRODUCTION TO THE STUDY AND DEFINITIONS OF TERMS

1. INTRODUCTION TO THE STUDY

Culture is the sumtotal of customs, beliefs, attitudes, values, goals, laws, traditions and moral codes of people. It includes their corporate view of the universe and also their attitudes to health and disease (Morley, 1973 p.43).

Most indigenous Zambians continue to have faith in traditional customs and beliefs which are part and parcel of their culture. In spite of the emerging scientific and technological advancement in modern medicine, the practice of traditional customs and beliefs still persist in the traditional Zambian society.

The traditional customs and beliefs are strongly adhered to. They influence and direct the mothers' actions toward diarrhoea especially the causes and its treatment. As a result of the influence, everytime the child has diarrhoea the mother is likely to seek help from a traditional healer. The reason for this being that, traditional healers live and practice among the people whose culture, beliefs and customs they understand. For example, a case study of a random sample of admissions to Paediatric Unit at U.T.H. by Khan et al (1977) revealed that ninety-five (95) percent of the children had first seen a traditional healer or had been treated at home by their grandmothers (Ministry of Health, UNICEF and WHO, 1977). This is a problem because it results in children being brought to hospital late, such that the health personnel are not given a chance to treat them successfully.

Morley (1973) says that mothers with sick children are frequently not satisfied with the treatment they get at the clinic or hospital. They have double requirements, treatment for the organic illness of their children and also traditional treatment for what they culturally believe is the cause of the disease. This illustrates that probably half the children with diarrhoea

in the hospitals receive apart from modern treatment, treatment based on local traditional customs and beliefs which are accepted, valued and understood by many indigenous mothers.

Observation and experience have also shown that health education given to the mothers regarding diarrhoea in children is not readily accepted by the clientele because health personnel fail to intergrate mothers' traditional customs and beliefs related to the condition.

The unharful customs and beliefs could be intergrated within the modern nursing techniques in order to ensure effective and efficient health care delivery to the mothers. The bad customs for example, the use of strong purgative herbal medicine as treatment for constipation in children which results in diarrhoea should be discouraged. Intergrating of traditional customs and beliefs that are harmless into health education programmes would help to influence some of the mothers who are convinced that the main cause of diarrhoea is related to traditional customs and beliefs and not necessarily it being a result of infection or dietary.

Traditional customs and beliefs always exert an impact on people who practice them. For example, mothers sometimes reluctantly bring their children with diarrhoea to the hospital because they lack faith in modern medicine and they do not understand the condition in its right perspective due to their traditional customs and beliefs concerning the disease.

Hence, it was felt necessary to identify mothers' traditional customs and beliefs related to diarrhoea in children, so that if and where possible solutions could be sought in order to improve and ensure efficient and appropriate health education on the condition. In the long term, infant morbidity and mortality due to diarrhoea will be reduced, children's hospitals will be less congested, and indirectly there will be a reduction on the high health budget incurred by the country especially if the high incidence of communicable diseases can be reduced through effective health education which is acceptable to the clientele.

The aims of the study are:-

1. To determine mothers' traditional customs and beliefs related to diarrhoea.
2. To assess parameters used by mothers in deciding whether to bring the children with diarrhoea to hospital or not.
3. To establish traditional treatment given to children with diarrhoea at home before they are brought to the hospital.
4. To determine what mothers think are the causes of diarrhoea.

2. DEFINITIONS OF TERMS

For the purpose of the study, the following terms are operationally

defined as:-

1. TRADITIONAL CUSTOMS

Refers to traditional customs and beliefs related to diarrhoea which are held and/or practiced by mothers.

2. DIARRHOEA

Loose watery stool more than five (5) times a day (Jelliffe, 1974 p. 21).

3. CHILDREN

Refers to a population group between six (6) and twenty-four (24) months admitted to U.T.H. with diarrhoea.

4. MOTHERS

Any Zambian woman who assumes responsibility of looking after a child whilst admitted in hospital for treatment of diarrhoea.

5. HEALTH PERSONNEL

Women or men with some form of training in health care delivery who attend to mothers when they come to the health centre.

CHAPTER 2STATEMENT OF THE PROBLEM

Diarrhoea is a major cause of morbidity and mortality rates in children. It is a major killer disease not only in Zambia, but in other developing countries as well. About five-hundred (500) million cases of diarrhoea are estimated to occur in children under five (5) years of age in Asia, Africa and Latin America. Out of the five-hundred (500) million, five (5) million die (Cash, 1980).

In Zambia, in 1982, fifty-two (52) districts out of fifty-seven (57), identified diarrhoea to be one of the major health problems in their districts. It accounted for 13.5 percent of the total out-patient visits and 13.2 percent of the total deaths in the rural health centres (Ministry of Health, 1983). However, in rural areas not served with Health centres, most of the suffering and deaths due to diarrhoea occurs in the villages and do not come to the health personnel, so the reported morbidity and mortality are an underestimation of the magnitude of the problem.

Although various studies have been done on treatment, control and prevention of diarrhoea in the country, none of the studies done looked at the traditional customs and beliefs regarding diarrhoea. It has been shown that lack of knowledge of the traditional health beliefs of people can be disastrous to health programmes. This is because people's reactions to illness are linked to their social and cultural behaviour (Nchinda, 1977).

In the indigenous society, there are many traditional customs practiced regarding diseases. These customs and beliefs determine not only the mothers' total reaction to the child's diarrhoea, but also her reaction to the kind of illness the child has. Hence, before Health personnel can think of ways of ^{education to} imparting health/ mothers of children with diarrhoea on the condition, they must examine their traditional customs and beliefs regarding diarrhoea. This is

important because children are cared for and reared in accordance with the traditional customs and beliefs of the cultural group to which their mothers belong. Without background knowledge of traditional beliefs and customs regarding diarrhoea, health personnel cannot understand the basis of the mothers' behaviour towards diarrhoea. Therefore, the alternative is for health personnel to take into consideration the clientele's traditional customs and beliefs which are related to diarrhoea if management is to be effective.

However, harmful traditional customs and beliefs should be discouraged through health education especially those that may interfere with effective management of the condition. For example, most mothers strongly believe that the following cause, diarrhoea in children:

- Breast feeding whilst pregnant
- Breast feeding in a public place such as ^amarket or a bus stop
- Breaking of child's first tooth

On the other hand, traditional customs and beliefs play a significant role in the control of diseases. For example, Lewis (1981) writing on the role of traditional healing says that the way man behaves is related to his cultural and traditional up-bringing. King (1966) talking on adaptation of medical care to local conditions emphasises that where possible, medical services should do what they can to improve the non medical aspects of culture in the promotion of a better life for the people. Ebrahim (1978) also states that health personnel should have a good knowledge of the beliefs and customs of the people they are serving, what the people believe about disease and its causes because these people have their own explanations for the occurrence of the disease. He further states that beneficial beliefs should be supported and strengthened the harmful practices should be discouraged and the neutral ones should not be interfered with. This way one avoids falling into the pitfall of attacking all local customs and beliefs indiscriminately.

Knowing and understanding of the traditional customs and beliefs regarding diarrhoea can help in ensuring effective and appropriate health education and thus help to lower the morbidity and mortality rates. Having noted the impact of traditional customs and beliefs, it has been felt necessary to identify the mothers' traditional customs and beliefs regarding diarrhoea in children aged six (6) to twenty-four (24) months.

The hypotheses of the study are:-

1. Most mothers' customs and beliefs regarding diarrhoea result in delay in bringing the children to the hospital and this makes it difficult to treat them successfully.
2. Mothers with low level of formal education associate causes of diarrhoea with witchcraft than mothers who have higher education.
3. Most mothers associate diarrhoea with teething.
4. Most mothers believe that breast feeding a baby in a public place causes diarrhoea.
5. Most mothers do not put into practice, the health education taught because it contrary to their traditional customs and beliefs regarding diarrhoea.
6. The older the mother, the more likely she is to practice traditional customs and beliefs.
7. Most mothers with high/^alevel of formal education are unlikely to practice traditional customs and beliefs related to diarrhoea even when they know them.

The study is going to answer the research question What are mothers' traditional customs and beliefs related to diarrhoea in children? The findings of the study will help in identifying mothers' traditional customs and beliefs related to diarrhoea in children, so that if and where possible solutions could be sought in order to improve and ensure efficient and appropriate health education on the condition. In the long term, infant morbidity and mortality due to diarrhoea will be reduced, children's hospitals will be less congested and indirectly there will be a reduction on the high health budget incurred by the country especially if the high incidence of communicable diseases can be reduced through effective health education which is acceptable to the clientele.

CHAPTER 3LITERATURE REVIEW

In Zambia, there is very little literature pertaining to traditional customs and beliefs regarding diseases. Zambia like any other society has its indigenous traditional customs and beliefs to which some people strictly adhere. This adherence influences their attitudes towards illness. The literature which is presented is from other countries and most of it, though ^{outdated} / 3 applies to the situations in some parts of the country in this regard.

The African looks upon many illnesses as due to the anger of the spirit guardian of the family concerned or to the witch (Gelfand, 1980). Africans in general take the customs and beliefs seriously and tenaciously adhere to them inspite of patient and laborious explanation of the disease/illness (Munyaradzi, 1975). The effects of customs, traditions and culture often give rise to deep seated prejudice and attitudes which must be understood before they can be broken down and re established (Hale etal, 1968).

One cannot understand the basis of the mothers behaviour towards diarrhoea without background knowledge of their traditional customs and beliefs. Jelliffe (1974) states that mothers may have quite different ideas as to what they believe to cause disease in their children. For example, it can be witchcraft or eating forbidden food. So, it is important that Health personnel know what is in their minds. Jelliffe continues to say that mothers will accept advice more readily and have more confidence if it is given with a knowledge of local customs. This is important because each culture respects and accepts certain values, attitudes and beliefs regarding diarrhoea and it is advisable that health workers do not work contrary to them. Otherwise conflict will ensue between the care providers and health consumers.

Health workers working in an unfamiliar area should try to find out as much as possible about local customs and they should use the good customs in teaching mothers by trying to change or modify bad customs through health education and by not bothering about unimportant customs (Jelliffe, 1974). In agreement with this assertion, Munyaradzi (1975) states that the fact that these African attitudes and beliefs to disease are real enough to them, it makes it imperative for those who are in daily contact with these Africans to try and understand these beliefs and attitudes. He goes on to affirm that this would make health personnel better equipped to deal with more bizarre and harmful aspects of those attitudes and beliefs, while allowing the fulfilment of the less harmful ones and thus appearing to be sympathetic and understanding. Furthermore, applying knowledge which comes to him as part of his cultural heritage, man transforms his physical environment to enhance his comfort to improve health (Landy, 1977). People seek to attain and maintain health provided there are no conflicting cultural forces (Hanlon and Pickett, 1979).

Health personnel should seriously make an effort to understand the indigenous traditional customs and beliefs regarding diarrhoea if they are to be successful in their work. They should be prepared to learn as much as possible about local medical beliefs which should include attitudes and practices associated with health, the prevention of disease, ideas as to causes of disease and methods of cure (Jelliffe and Bennett, 1960). This is important because knowing the mothers' traditional customs and beliefs pertaining to diarrhoea in children will make health personnel understand some of the reasons why mothers prefer to treat their children with traditional diarrhoea treatment before bringing them to the hospital. Foster (1965) emphasising the importance of the above point states that the health advisor unless he is a careful worker of the culture in which he works, may make disastrous decisions. Thus, it is advisable to ensure that the advice given to the local community is not in conflict with their beliefs, attitudes and ideas which minimizes the risk of having the advice rejected.

An individual learns customs and beliefs from his birth and through his life time, such that they become part and parcel of him, His culture determines how he thinks, acts and treats the sick (Smolensky and Hamr, 1972). The traditional customs and beliefs regarding diarrhoea are therefore inherited in total for better or for worse and as such are bound to influence the mothers' reaction towards the condition. For example, in the Northern Province of Zambia, if a child has diarrhoea and the mother believes it is caused by her breast feeding whilst pregnant, she will treat the child with beans cooked together with roots from acacia macrothyrsa (umutaba) tree (this condition is called ulunse), a practice which a mother would have known since childhood and as such, will not think of going to the hospital. Once an illness/disease is established, treatment consists of identifying the cause of the illness first and then the appropriate treatment is sought for by either conciliating the ancestral spirits or taking an antidote against the witches' poison (Munyaradzi, 1975).

Smith and Kane (1970) state that mothers of suffering children seek for medical or traditional healers' advice depending on the precipitating factors which make them do so. Among them, knowledge of health and level of recognition of the causes, symptoms and the prognosis of the illness. Therefore, the mother's knowledge about diarrhoea determines her response.

King (1966) points out that culture is logically intergrated dynamic whole and not merely an accidental collection of customs. In this regard, the good aspects of traditional customs and beliefs regarding diarrhoea should be carefully adapted to the opportunities and limitations of the local culture. Paul (1955) in agreement with King, states that if one wishes to help a community improve its health, he must learn to think like the people of the community before asking them to assume new health habits. Advice given to mothers should be constructive rather than destructive, the traditional cultural way of life of the community must be taken into account and utilised. It is, therefore, wise to ascertain the existing traditional customs and beliefs regarding diarrhoea and how these habits are linked to one another, their function and what they mean to the mother who

practices them. This is of paramount importance because an explanation, no matter how truthful which conflicts with the patients' own ideas or which seems to indict the patient for ignorance or superstition may result in emotional disturbance or termination of treatment (Weisz, 1972).

Health care achieves greater success when it is rendered in a style which is relevant to the social, cultural and economic status of the people to whom these services are directed (Adegoroye, 1984). It is vital for health personnel to know the mothers' traditional customs and beliefs regarding diarrhoea so that the advice given is based on these. Knowledge about these beliefs and customs can help the health personnel to make appropriate interventions. An understanding of the functioning of society and of the all pervading nature of culture is essential if a nurse is to give fully effective nursing care (Congalton, 1976). It is a necessity that modern therapists study traditions in order to understand popular attitudes surrounding maladies he may come in contact with (Weisz, 1972). This would make it possible for him/her to know the feelings the mother is likely to have about diarrhoea and the methods of treatment she is likely to trust.

Ainsworth (1982) emphasises that provision of health education relevant to the local culture and environment will increase their awareness of how to stay healthy through self reliance. This is possible because it is established that cultural factors are deeply imbued among other things in matters of personal hygiene, seeking early treatment and child rearing (Park, 1972). From this, one can say that basing health education on the local traditional customs and beliefs regarding diarrhoea lessens the mothers' conflicts on whether to adopt the health personnels' advice on causes and treatment of diarrhoea or to continue with their old traditional customs and beliefs concerning the disease.

Chaeko (1977 p. 122) says the main role of the nurse in health education is to:

/...

Impart health education that would result in a change of knowledge, that results in a change in behaviour that would establish a change in habit and ultimately a change of custom.

The fact that traditional customs and beliefs regarding diarrhoea in children play a major role in deciding whether to seek medical advice or not, it is important that these traditional customs and beliefs are assessed so that the harmless are encouraged and the harmful customs and beliefs are discouraged through health education. For example, in some parts of Zambia beads and other talismans are wrapped round the waist of the child to prevent and arrest diarrhoea (Khan et al, 1977). The health personnel may find it hard to understand the action of this harmless practice, but since the charms may have a psychotherapeutic effect especially on the mothers without necessarily having any harmful effects on the child this custom can be encouraged or left uninterfered.

Simwanza (1984) points out that one of the major obstacles for successful delivery of health education in Zambia may be due to the cultural resistance of the mothers. Hanlon and Pickett (1979) in agreement with the above statement say that health programmes are frequently hampered by failure to inquire into or understanding customs that the members of a group consider important. Observation and experience have also shown that there is a common tendency among trained health personnel to ignore if not to ridicule the clients' traditional customs and beliefs related to diarrhoea. This probably reduces the effectiveness of the advice given to the mothers on diarrhoea in children.

Reimer (1983) says that nurses must have additional information regarding the distribution pattern of these traditional customs and beliefs in the client population. If this is done, it will make Health personnel work effectively especially that they work in a society where most people are strong about their traditional customs and beliefs regarding diarrhoea. This would also facilitate an effective two way communication which would help in elimination of suspicious

attitudes. It is therefore, vital that people are assisted in their attempts to implement the recommendations made on prevention, control and treatment of diarrhoea by intergrating the advice with the rest of their cultural patterns.

Cultural background can serve as a cue to the health personnel. They should be sensitive to cultural beliefs and practices regarding diarrhoea in children and should not over generalise them because it is not all members of the sub-culture who hold to a particular belief or practice. The clients or patients differ in their cultural patterns and this affects their responses to particular types of disease (Baker and Northman, 1981). However, regardless of the cultural background of the client, she should be served without discrimination and with regard to her culture.

In view of the above, it is important that nurses look at mothers and the clientele in general as unique individuals with individual traditional customs and beliefs. This is the only way the health personnel are likely to give appropriate and effective health education on diarrhoea to the mothers.

In conclusion, therefore, it is necessary to find out the mothers' traditional customs and beliefs regarding diarrhoea so that health education on diarrhoea in children can be successfully delivered to the mothers. This hopefully will help to reduce the increasing morbidity and mortality rates of diarrhoea.

CHAPTER 4METHODOLOGY1. RESEARCH DESIGN

The purpose of the study was to identify mothers' traditional customs and beliefs related to diarrhoea in children who are admitted to University Teaching Hospital. A descriptive survey design was used because it was thought to be more appropriate to the study since the nature of the data collected was in descriptive form.

Descriptive surveys are studies which are designed to describe phenomena (Treece and Treece, 1982). Sweeney and Olivieri (1981) define a descriptive study as a research study carried out for the purpose of providing an accurate portrayal of a group of subjects with specific characteristics and entail the precise measurement of phenomena as they currently exist. Thus, the study aimed at identifying the mothers' traditional customs and beliefs regarding diarrhoea in children including the parameters used by mothers to decide whether to bring their child with diarrhoea to the hospital or not. The subjects remained in their natural setting during the interview and were therefore, not subjected to unpleasant conditions and hence cooperation was easily obtained. Lastly, Abdallah and Levine (1979) say that descriptive studies are less expensive and enhance the completion of the study in a short period of time. Gathering of data in descriptive survey provides an opportunity to examine variables because it is done in a natural setting (Seaman and Verhomick, 1982). Therefore, the design allowed gathering data in the U.T.H.'s Ward A06 (Rehydration Ward). Furthermore, data are collected from already existing resources.

2. RESEARCH SETTING

The study was conducted at the University Teaching Hospital (U.T.H.) which is the largest hospital in Zambia. It has a bed capacity of one thousand five hundred (1,500) distributed among six departments namely:- Paediatrics, Medical,

Surgical, Obstetrics and Gynaecology, Neonatal Surgical and Administrative department. U.T.H. serves as a referral hospital for the whole country because it has most of the specialist doctors. It has training services for registered nurses and midwives, theatre nurses, nurse tutors, doctors and theatre assistants. Physiotherapists, Radiographers, Laboratory Technicians, Dental assistants, Clinical officers, Health Assistants and Psychiatric Enrolled Nurses come to U.T.H. for their practical experience.

On 2nd April 1985, Parliament passed the Medical Services Act 1985 which established management boards for government hospitals. Arising from this Act, University Teaching Hospital was on 1st July 1985 made an autonomous parastatal body with a Chairman as the figurehead of the Management Board. The Board Members are appointed by the Minister of Health. The overall functions of the Board are run by the Executive Director. The administrative duties on the other hand, are undertaken by the Board Secretary and other staff under the supervision of the Director.

From 1st July 1985 U.T.H. ceased to operate as a general hospital. It instead reverted to its original concentration as a referral and teaching hospital. This will be achieved by expanding the Health centres in order for them to handle simple cases which do not require hospital attention.

In terms of financial accountability, the U.T.H. Board has powers to receive, borrow and invest money in pursuance of its functions. The financial affairs in the form of audited financial statements (balance sheet, income and expenditure statement) will be submitted to the Minister of Health who will table the same in Parliament (The Medical Services Act, No. 14 of 1985).

U.T.H. was chosen for the setting because of its proximity to the institution of learning. Secondly, it provided for data collection ^{from} the subjects who comprised of high, medium and low income groups in one area. This was important because the study was conducted within a limited period of time.

The study was conducted in Paediatrics Department which caters for children below the age of twelve (12) years. The department has a capacity of two hundred (200) beds and cots. It has an average patient turnover of three hundred (300) patients per day. This is possible because most children share cots and beds. The department has its own outpatient, pharmacy and x-ray departments.

There are four wards which are A02, A04, A05 (isolation) and A06 (Rehydration Unit). Ward A04 is the biggest ward in the department with twenty-nine (29) beds, twelve (12) cribs, fifty-one (51) cot beds, two (2) working incubators and twenty (20) nurses. Ward A02, the second biggest has forty (40) cot beds, twelve (12) beds, nineteen (19) cribs, two (2) incubators and fifteen (15) nurses. Ward A05 (isolation Ward) has seven (7) beds and forty-three (43) cots with nine (9) nurses working on the ward. Lastly, Ward A06 has twenty-four (24) cots, twenty (20) cribs and one (1) bed with a total of ten (10) nurses. Ward A06 was used for the selection of respondents because it is specifically used for treatment and nursing of children with diarrhoea.

Ward A06, like any other ward at U.T.H. is managed over three shifts in a twenty-four (24) hour period. The night shift being the longest lasting up to thirteen (13) hours. The number of nurses in the wards is not adequate to cover the three shifts in a twenty-four (24) hour period. For example, in Ward A06, there are approximately two (2) to three (3) nurses per shift. An adequate number of nurses per shift is required in order to provide quality care for the patients.

In addition to the four (4) wards, there is a special observation unit where children who are critically ill are nursed. This Unit has two (2) cots, two (2) beds and five (5) nurses.

In the paediatric department, they have a nutrition centre as well, where cooking demonstrations are carried out on Tuesday mornings. The food cooked is only for the children admitted in the department with Protein energy malnutrition. Milk is prepared by the nutrition demonstrators for the children with kwashiorkor and the babies in the nursery. The other older children get milk. Both tea and milk are prepared four (4) times in a day. At the centre, there are three (3) public health nurses, one nutritionist, nine (9) nutrition demonstrators and one family health nurse.

3. PILOT STUDY

A pilot study is that study which is done preliminary to the main study with the aim of testing the elements for the study proposal and correcting any inconsistencies (Seaman and Verhomick, 1982). It is a trial run of the major study and can be used to test the data collecting instrument to see whether the questions are clear (Polit and Hungler, 1978). It therefore, provides the opportunity to carryout the procedure, for collecting data (Treece and Treece, 1982) and tests the validity and reliability of the instrument to be used in the study for data collection.

A pilot study was not done due to limited time in which the study was conducted, compiled and submitted to the Department of Post-Basic Nursing, and also because of other academic pressures. However, since a study of this nature has not been conducted before, it can be said to be a pilot study in itself. The inconsistencies in the instrument for data collection were checked by the supervising Lecturer and colleagues to ensure validity and reliability of the instrument, clarity and sequence of questions.

4. SAMPLE : SELECTION AND APPROACH

The target population were Zambian mothers whose children were admitted with diarrhoea in Ward A06. The sample was drawn from these mothers for two (2)

reasons. Firstly, the study was on Zambian mothers with children admitted to A06. Secondly, identifying Zambian customs is more beneficial to the health educators nationally as most of them are likely to be the same or similar. Mothers with children admitted with diarrhoea in other wards with other complaints like measles or kwashiorkor were excluded from the study because diarrhoea was not the main problem. Non Zambian mothers were also excluded from the study because the investigator was only interested in the Zambian traditional customs and beliefs.

Permission to interview the mothers was sought for both verbally and by letter to the Acting Nursing Officer of Paediatric department on 27th January, 1986 (Appendix 1). A written reply granting permission to conduct the study in the department was received dated 29th January, 1986 (Appendix 2). The sister-in-charge, the nurses as well as the mothers of the children on the ward were personally informed about the purpose of the study. The Nursing Officer also took the responsibility of informing the sister-in-charge about the request to interview the mothers in the ward.

A sample of forty (40) mothers was obtained. It was intended to obtain a sample of fifty (50) mothers of children admitted to Ward A06 with diarrhoea but unfortunately it was later discovered that it was not a season for diarrhoea thereby ending up with a sample of only (40) respondents. The sample size was small due to the time limit in which the study was to be completed, therefore, findings should be generalised with caution. In addition, the data collecting instrument-interview schedule is time consuming if one has a large sample size.

The purposive sampling method was used to select the sample. This is a form of non-probability sampling in which the researcher selects a special group Treece and Treece, (1977) which was Zambian mothers with children aged six (6) to twenty-four (24) months admitted to Ward A06 with diarrhoea. The subjects were chosen deliberately because the target population was limited. This sampling method is good because there is good evidence that it is representative of the

of the total population to be studied.

5. DATA COLLECTION INSTRUMENT

Data were collected using the structured interview schedule (Appendix 3) which allows for collection of fairly consistent data (Sweeney and Oliveri, 1981). The information collected is uniform because it was collected by the same instrument. Opportunity was accorded to the interviewer to make observations on the environment as well as pick both the verbal and non verbal cues from the respondents. Questions which were not clear to the respondents were rephrased or clarified as the interviewer was present. It also provided an opportunity for illiterate mothers to participate in the study, this is good because their contributions are equally valuable to the study. The interview schedule has the following advantages:-

1. The observer does not need to be too highly skilled in the interviewing process.
2. The response rate is high because of face to face interaction.
3. Interviewer maintains control over the sample because respondents are the intended participants.
4. In interview technique all data obtained are usable (Treece and Treece, (1977 p. 245).
5. The respondent is saved time to fill in the responses and return the questionnaire to the researcher.
6. The structured interview allows the interviewer to probe in order to clarify and broaden responses (Abadallah and Levine, 1979 p. 339)
7. The researcher has strict control over the order of presentation of questions in an interview (Polit and Hungler, 1979 p. 352)

The interview schedule has the following disadvantages:-

1. It can be costly depending on the number of respondents and length of interview (Treece and Treece, 1977 p. 246)
2. Face to face interaction decreases the respondents feeling of anonymity.
3. It is subject to bias

4. When more than one interviewer is used it may be difficult to make a comparison (Seaman and Verhonick, 1982 p.p 217-219)

Some of the disadvantages were minimised by assuring respondents' anonymity and confidentiality by not recording their names on the interview forms and there were no other interviewers. Rapport was established by the interviewer being introduced to the mothers in the ward by the staff nurse in-charge, there after the aim of the study was explained to the respondents as a group before they were individually interviewed. The interview was kept informal, this way respondents' felt free to answer and ask questions.

6. QUESTION SEQUENCE

The interview schedule consisted of seventeen (17) questions. The first four (4) questions sought for information on demographic data such as age, educational attainment, occupation and the respondents' residential areas. Questions five (5) and six (6) sought for information regarding their tribe and marital status.

Information regarding the number of live and dead children, what the dead children died of and what their ages were when they died was sought for in questions seven (7) and eight (a, b, c and d).

Questions 9, 10, 11 and 12 elicited data on where respondents normally deliver their children, for how long they breast feed, age of the admitted child and for how long he has had diarrhoea. The respondents were asked the meaning of diarrhoea, its causes and what they do when the child has diarrhoea in questions 13, 14 and 15 a, b, c, d, e and f.

The last two (2) questions (16 and 17) sought to find out respondents parameters used to decide to bring the child to hospital and whether they practice the health education taught at the health centres regarding diarrhoea.

7. DATA COLLECTION

Data collection was done between the third week of February, and the second week of March 1986. The interviews were stretched over a period of five weeks because of other academic pressures, so the interviewer was not able to conduct interviews on a daily basis. The data were collected by interviewing mothers of children admitted to Ward A06 with diarrhoea. The interviews took place in the ward in a small room normally used at tea break by doctors and nurses. This ensured privacy and mothers talked freely.

Mothers were approached as a group. After self introduction they were told the purpose of the study and how the findings will be used in order to gain their cooperation. The mothers were given the freedom to volunteer to participate in the study or not. Fortunately all volunteered and were interviewed individually.

The interviews were conducted on Thursday afternoons, Friday mornings and any other free time the interviewer had. Afternoons were more suitable because by then most ward activities had been done in the morning such as doctors' round and nursing activities which are carried out in the morning, this facilitated a quite atmosphere conducive to interviewing.

8. LIMITATIONS OF THE STUDY

During the conduct of the study, a number of limitations were encountered. Literature on Zambian traditional customs and beliefs related to diarrhoea could not be found though studies on other aspects of the condition were found. This made it difficult to relate the results.

The other reason is the limited time in which data were to be collected and the study completed for submission to the School of Medicine, Department of Post Basic Nursing. This was coupled with the problem of few children admitted with diarrhoea as this was not the season when there are a lot of cases with diarrhoea.

This meant that the sample had to be made small in order to collect data which could be analysed within the stipulated time. Hence, results cannot be generalised to all the mothers.

Lastly, the reliability of the instrument was not pre-tested and some questions therefore were not critically analysed before execution of the study.

CHAPTER 5

DATA ANALYSIS AND PRESENTATION OF FINDINGS

1. DATA ANALYSIS

The purpose of the study was to determine the mothers' traditional customs and beliefs related to diarrhoea and also to find out the parameters used by mothers in deciding whether to bring the children with diarrhoea to hospital or not.

Data analysis is the process by which the researcher summarises and describes data and if possible, makes inferences from the study sample to the population from which the sample was drawn (Seaman and Verhomick, 1982). The data collected for the study were analysed manually with the aid of a pocket calculator and responses were processed and categorised. Data collected are not useful unless arranged in a meaningful manner so that it is possible to derive patterns of relationships (Polit and Hungler, 1983).

The findings are presented in table form because tables conserve space by presenting data in such a way that the narrative may be reduced and that tabulated data is easier to remember (Seaman and Verhomick, 1982). The tallying method of four (4) vertical bars and slash for the fifth (5) observation was used. For example, number of responses ~~+++~~ ~~+++~~. The tallying of data on worksheets brings together in one place the data collected on all the study subjects (Abdellah and Levine, 1983). The data were arranged in frequency counts and percentages. Polit and Hungler (1983) state that percentages are descriptive statistics used to describe and synthesize obtained empirical observations and measurements.

2. FINDINGSTABLE 1: AGE DISTRIBUTION OF RESPONDENTS

AGE IN YEARS	NUMBER OF RESPONDENTS	PERCENTAGE
25 - 29	15	37.5
20 - 24	10	25
15 - 19	5	12.5
30 - 34	5	12.5
40 and above	3	7.5
35 - 39	2	5
TOTAL	40	100

TABLE 2: RESPONDENTS' EDUCATIONAL ATTAINMENT

EDUCATIONAL ATTAINMENT	NUMBER OF RESPONDENTS	PERCENTAGE
Grade 5 - 7	20	50
None	6	15
Grade 1 - 4	4	10
Grade 10 - 12	4	10
Grade 8 - 9	3	7.5
College	3	7.5
TOTAL	40	100

TABLE 3: OCCUPATIONAL STATUS OF RESPONDENTS

OCCUPATION	NUMBER OF RESPONDENTS	PERCENTAGE
House-wife	28	70
Self-employed	6	15
Typist	3	7.5
Tailor	2	5
Teacher	1	2.5
TOTAL	40	100

TABLE 7: MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Married	33	82.5
Single	4	10
Divorced	2	5
Widowed	1	2.5
TOTAL	40	100

TABLE 8: NUMBER OF CHILDREN PER RESPONDENT

NUMBER OF CHILDREN	NUMBER OF RESPONDENTS	PERCENTAGE
1 - 3	23	57.5
4 - 6	15	37.5
7 - 9	2	5
TOTAL	40	100

TABLE 9: PLACES WHERE MOTHERS DELIVERED THEIR CHILDREN

PLACE OF DELIVERY	RESPONDENTS	PERCENTAGE
Health Centre	21	52.5
Home	14	35
Health Centre or at Home	5	12.5
TOTAL	40	100

TABLE 10: AGES OF THE ADMITTED CHILDREN

AGE IN MONTHS	NUMBER OF CHILDREN	PERCENTAGE
9 - 11	16	40
6 - 8	12	30
12 - 14	3	7.5
15 - 17	3	7.5
18 - 20	3	7.5
24 and above	2	5
21 - 23	1	2.5
TOTAL	40	100

TABLE 11: NUMBER OF DAYS CHILDREN HAD DIARRHOEA

NUMBER OF DAYS	NUMBER OF CHILDREN	PERCENTAGE
2 - 4	28	70
5 - 7	5	12.5
8 - 10	4	10
14 and above	2	5
11 - 13	1	2.5
TOTAL	40	100

TABLE 12: RESPONDENTS' OWN UNDERSTANDING OF DIARRHOEA

UNDERSTANDING OF DIARRHOEA	NUMBER OF RESPONDENTS	PERCENTAGE
A disease	22	55
Frequent loose stool	10	25
Abdominal problem	5	12.5
Does not know	3	7.5
TOTAL	40	100

TABLE 13: WHERE RESPONDENTS GO FIRST WHEN THEIR CHILDREN HAVE DIARRHOEA

WHERE THEY GO	NUMBER OF RESPONDENTS	PERCENTAGE
Clinic	21	36.8
Neighbour	16	28.1
Private Doctor	8	14
Mother	7	12.3
Traditional Healer	5	8.8
TOTAL	87	100

TABLE 14: RESPONDENTS REASONS FOR BRINGING THEIR CHILDREN TO THE HOSPITAL

REASONS	NUMBER OF RESPONDENTS	PERCENTAGE
Condition did not improve	36	90
Referred from the Clinic	3	7.5
Dehydration	1	2.5
TOTAL	40	100

TABLE 15: NUMBER OF RESPONDENTS WHO HAVE LOST CHILDREN

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	18	45
No	22	55
TOTAL	40	100

TABLE 16: NUMBER OF CHILDREN LOST BY 18 RESPONDENTS

NUMBER OF LOST CHILDREN	NUMBER OF MOTHERS	PERCENTAGE
1	9	50
2	6	33.3
3	3	16.7
TOTAL	18	100

TABLE 17: CAUSES OF DEATH OF THE CHILDREN

CAUSES OF DEATH	NUMBER OF MOTHERS	PERCENTAGE
Diarrhoea	7	38.9
Measles	3	16.7
Malaria	2	11.1
Bleeding umbilical cord	2	11.1
Pneumonia	2	11.1
Do not know	2	11.1
TOTAL	18	100

TABLE 18: CHILDREN'S AGES AT THE TIME OF DEATH

AGE IN MONTHS	NUMBER OF MOTHERS	PERCENTAGE
6 - 10	7	38.9
Do not know	5	27.8
16 - 20	2	11.1
21 - 25	2	11.1
11 - 15	2	11.1
TOTAL	18	100

TABLE 19: LENGTH OF TIME RESPONDENTS BREASTFED THEIR CHILDREN

LENGTH OF TIME IN MONTHS	RESPONSES	PERCENTAGE
18 - 20	19	38
15 - 17	13	26
12 - 14	9	18
24 and above	6	12
21 - 23	3	6
TOTAL	50	100

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TABLE 20: NUMBER OF RESPONDENTS WHO GIVE THEIR CHILDREN SOME MEDICINE BEFORE BRINGING THEM TO THE HOSPITAL

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	28	70
No	10	25
Sometimes	2	5
TOTAL	40	100

TABLE 21: THE TYPE OF MEDICINE GIVEN TO CHILDREN BEFORE THEY ARE BROUGHT TO THE HOSPITAL AND HOW THIS MEDICINE IS PREPARED

TYPE OF MEDICINE			PREPARATION OF MEDICINE		
MEDICINE	NUMBER OF RESPONSES	PERCENTAGE	PREPARATION	NUMBER OF RESPONSES	PERCENTAGE
Traditional	18	60	Traditionally	23	76.7
Modern	6	20	Technically	4	13.3
Both modern and traditional	6	20	Do not know	3	10
TOTAL	30	100		30	100

TABLE 22: PERSONS WHO SUPPLIED MOTHERS WITH MEDICINE

PERSONS	NUMBER OF RESPONSES	PERCENTAGE
Neighbour	17	32.7
Self	14	26.9
Mother	9	17.3
Pharmacist	7	13.5
Traditional Healer	5	9.6
TOTAL	52	100

TABLE 23: THE EFFECT OF THE MEDICINE ON DIARRHOEA

EFFECT	NUMBER OF RESPONDENTS	PERCENTAGE
Stops diarrhoea	32	80
Stops abdominal pains	5	12.5
Other	3	7.5
TOTAL	40	100

TABLE 24: NUMBER OF RESPONDENTS WHO PRACTICED THE HEALTH EDUCATION REGARDING DIARRHOEA WHICH IS TAUGHT AT THE HEALTH CENTRES

RESPONSE	NUMBER OF RESPONDENTS	PERCENTAGE
Yes	31	77.5
No	4	10
Some, not all	3	7.5
Sometimes	2	5
TOTAL	40	100

Most mothers attained grades five (5) to seven (7) because there are more dropouts from school at this level due to fewer school places in grade 8 in the country compared to grade 7 places. It is good that most respondents had some formal education because even though it is minimal it exposes them to extra knowledge than those who never ^{went} to school at all. Grant (1984) says that female education is one of the best health investment which a developing country can make for its own future, for education has a factor in mortality decline. He further writes that mothers education is the key determination of her children's health. Grant (1985) also states that a child born to a mother with no education has been shown to be twice as likely to die in infancy as a child born to a mother with even four (4) years of schooling. It is usually the mother who is responsible for deciding whether bouts of diarrhoea will be treated by withholding food or by continued feeding.

Table 3 p. 23 shows that 70 percent of the mothers were unemployed (fulltime housewives), 15 percent were self employed and 7.5 percent were typists. Five (5) percent were tailors, one (1) of the mothers was actually a supervisor in a tailoring shop and the other worked in a factory where they knit sweaters or cardigans. Only a small number of the respondents were gainfully employed. This is because most of the respondents did not have the education to enable them to enter into college for specific job training or to learn some skill. In the absence of this wage labour, some mothers resort to petty trading and small scale manufacturing within the townships, so that they can supplement their husbands' wages.

A good number of the mothers in the study (52.5 percent) were from high density areas, 30 percent lived in medium density areas whereas 17.5 percent came from low/^{density} residential areas. The high density areas are generally known to be of poor environmental sanitation which consequently results in increase in cases of diarrhoea in children in these areas. Benenson (1970) subscribes to this view when he says that diarrhoea of less developed countries is universally present and common in areas of poor sanitation and prevailing malnutrition.

Diarrhoeal diseases are often related not only to the protected and available water supply but to the attention of individuals to washing their hands, collecting water in clean buckets and drinking it out of a clean cup (Williams and Jellife, 1976). Adagoroye (1984) says diarrhoea occurs mostly in low socio-economic environments where sanitation is poor and water is scarce. So it is important that both personal and environmental hygiene are maintained in order to prevent diarrhoea.

Table 5 p. 24 reveals that the majority of the respondents (30 percent) were Tonga by tribe, Lozis and Bembas were 27.5 percent each. Ten (10) percent were Nsengas and 5 percent were Luvales. Probably there were more Tongas because of the proximity of Lusaka to southern province where the Tongas come from. The findings have revealed that mothers from the same tribe share the same beliefs though, most of them mentioned that they have learnt other customs and beliefs from other tribes because of having been in town for a long time and mixing with people from other tribes. For instance, most mothers as shown in table 6 p. 24 mentioned that diarrhoea was due to breastfeeding in public places like the market, bus stop or in a bus. This belief is from Eastern Province only but now most mothers know it and get medicine from people from Eastern Province to protect their children against it. This condition is locally known as 'chibele.' The child produces whitish watery stool.

All respondents know some form of traditional customs and beliefs related to causes of diarrhoea in children as shown in Table 6. 24. Though it was envisaged that the older the mother the more likely she is to practice traditional customs and beliefs related to diarrhoea, the findings are contrary to this. They have revealed that even younger mothers who were actually the majority (30 years and below) as shown in Table 1, know some traditional customs and beliefs related to diarrhoea. Therefore, hypothesis number 6, which says that the older the mother the more likely she is to practice traditional customs and beliefs is not necessarily true.

The following beliefs were said to be the causes of diarrhoea:-

1. Teething which accounted for 30.9 percent of the responses. Most mothers said breaking of a child's first teeth results in diarrhoea.
2. Almost 30 percent (28.9 percent) of the responses mentioned breastfeeding whilst pregnant.
3. Breastfeeding in public places were 24.9 percent of the responses.
4. Others were 5.2 percent of the responses

The beliefs in number 4 above were that diarrhoea is a seasonal disease in autumn when trees get new leaves. The other belief was that if a mother had extra marital relationship then she breastfeeds or just feeds the child, he will end up with diarrhoea.

However, 10.3 percent of the mothers said it was due to bad food and dirty water. Thus, hypothesis number 2 which says mothers with low level of formal education associate causes of diarrhoea with witchcraft than mothers who have higher education is neither rejected nor accepted because most mothers had low level of formal education and only 7.5 percent as shown in Table 2 p. 23 had higher level of education. Secondly, the sample size was small as to make inferences to the total population of mothers whose children had diarrhoea. Teething was the most common response mentioned to be the cause of diarrhoea. Experience and observation have shown that child's breaking of first teeth is associated with diarrhoea. This probably could be attributed to the fact that during this time (oral phase) any thing that the child picks, clean or not, he puts it in his mouth and wants to bite anything that goes in his mouth. Oral phase covers the first year of life. So termed because the mouth is the primary pleasure zone. The infant associates the pleasure of hunger satisfaction with oral stimulation and soon learns to stimulate his mouth for pleasure. With eruption of teeth and increasing muscular control the child has a more aggressive approach to his environment (Watson and Lowrey, 1967). It is also probable that the diarrhoea can result from the child's action of putting even dirty things in

the mouth during the teething period. Bennett et al (1972) in their study on concepts of diarrhoeal diseases report a similar finding. Most mothers gave teething as the main cause of diarrhoea. Therefore, the fourth (4) hypothesis which says most mothers associate diarrhoea with teething is accepted.

Another common belief was breast feeding whilst pregnant. Simwanza (1984) in her study revealed that 58 percent of the mothers discontinued breastfeeding when they discovered that they were pregnant for fear of their children having diarrhoea. Though scientifically there is no harm in breastfeeding during pregnancy, most mothers in the country strongly adhere to the belief and stop breastfeeding their children as soon as they discover that they are pregnant. However, some people have been known to have breastfed two children together but of course giving priority to the baby since the older child was having other foods as well.

Breastfeeding in public places was the third (3rd) most common belief mentioned. Thus the 5th hypothesis which ^{implies} that most mothers believe that breastfeeding a baby in a public place causes diarrhoea may be true.

In Table 7 p.25 it is shown that most of the respondents were married (82.5 percent). Ten (10) percent were single, 5 percent were divorced and 2.5 percent were widowed. Fifty-seven point five (57.5) percent of the respondents had between one (1) and three (3) children, 37.5 percent had between four (4) and six (6) children and 5 percent had between seven (7) and nine (9) children (Table 8 p. 25).

Most mothers ^{delivered} their babies at health centres (Table 9 p. 25). Fifty-two point five (52.5) percent delivered at the health centres, 35 percent delivered at home and 12.5 percent delivered some of the children at health centres and some at home. It is good that most of the mothers utilised the health centres. Most of them indicated that they went to deliver at the health centre when they were told to do so by the midwife or when they had discomforts during pregnancy or when there was nobody reliable in the neighbourhood or at home to deliver them or to assist them.

Ages of the admitted children are shown in Table 10 p. 26. Forty (40) percent were aged between nine (9) and eleven months, 30 percent were between six (6) and eight (8) months. Seven point five (7.5) percent of the children were in the age ranges of twelve (12) to fourteen (14), fifteen (15) to seventeen (17) and eighteen (18) to twenty four (24) months respectively. Five (5) percent were aged twenty-four (24) and above months and 2.5 percent were twenty-one (21) to twenty-three (23) months. It is not surprising that there were more children in the nine (9) to eleven (11) age group because diarrhoea is more prevalent during the weaning stage. This is because children are introduced to new types of foods during this stage. Seventy (70) percent of the children had been admitted in the ward for two (2) to four (4) days. Twelve point five (12.5) percent had been in for five (5) to seven (7) days, 10 percent for eight (8) to ten (10) days, 5 percent, fourteen and above days and 2.5 percent for eleven (11) and thirteen (13) days respectively. (Table 11 p. 26).

Most mothers in the study (55 percent) said diarrhoea was a disease, 25 percent said it was frequent loose stool, 12.5 percent said an abdominal problem and 7.5 percent did not know what it is (Table 12 p. 26). Traditionally it is believed by most people that diarrhoea is a disease with known causes and treatment. Probably this is why most mothers said it was a disease. However, it is good to note that quite a good number of the respondents (25 percent) knew that it was frequent loose stool. In any case one would say that most of the mothers had some right idea of what diarrhoea is. Maegraith and Leithead (1962) say that diarrhoea is present if there is abnormal frequent and liquidity of stools termed 'loose stools' and it may be accompanied by colic and tenesmus. Aarons and Hawes (1979) also define diarrhoea as frequent watery stools often accompanied with swollen belly with cramps. Another reason why most mothers had the right idea of what diarrhoea is is that, most mothers (50 percent) as shown in Table 2 p. 23 had some formal education between grades five (5) to seven (7) which is upper primary school level where diarrhoea and other hygiene related topics are taught. Also at the moment, there is a WHO diarrhoeal prevention and control programme going on

in the country and most institutions of learning the mass media and health centres are frequently talking and writing about the condition. In almost all the health centres, there are posters on diarrhoea and since most mothers said they visit the health centres ^{frequently,} / it is likely that they have had health education talks on the condition. This shows that the health education being given is having some impact on the mothers.

Table 13. p 27 reveals that 36.8 percent of the mothers go to the clinic first when their children have diarrhoea. This shows that most mothers have more faith in modern medicine as opposed to traditional medicine. Gelfand (1977) says that Africans have no real opposition to Western medicine, they often consult a Western doctor with the hope that he can recognise and cure their illness. The minimal formal education attained by most mothers in the sample contributed to the high percentage of mothers who bring their children to the clinic first when they have diarrhoea. Grant (1985) says the education of women greatly changes the traditional balance of familiar relationships with profound effects on child care. An educated woman would rather take her child with diarrhoea to the hospital than to first go to the mother or grand mother for advice, this is because she understands the condition in its right perspective and knows the risks of doing so. Table 18 p. 28 further reveals that 28.1 percent of the responses were that they go to the neighbours first before coming to the hospital when their children have diarrhoea. It is a common practice among most mothers that when their children are sick, they first go to seek for help or advice from the elderly or those respected persons who live close to them. This is because some of these people are known to be experts in certain problems. If a child is ill, it is often the neighbour who is the nearest source of help and who will be the first to discuss with the mother what care is needed (Amonoo - Lartson et al, 1984). After consulting the neighbours and nearby relatives, the decision as to who should be seen will depend on what they will think is the cause of the illness and which services they think will be able to help. All this results in delay in bringing

the child to the hospital for prompt effective and efficient treatment.

Fourteen (14) percent of the mothers said they go to the private doctor first before coming to the hospital. The reason given for this was that, they are sure that their children will get injections and undiluted diarrhoeal mixture. Some mothers said that their children became better faster when they took them to private doctors and pay for treatment than when they came to the hospital. Twelve point three (12.3) percent of the respondents said they go to their mothers first when their children have diarrhoea before bringing them to the hospital or clinic. These were young mothers with one or two children and had their mothers living near them and those who were not married and were still living with their parents. This is probably due to lack of experience of child rearing. Uberoi et al (1974) say that, mothers and families are the most important persons in caring for children and are responsible for the health of their children.

Observation and experience have shown that grandmothers and old women especially like to teach the young mothers who may be their daughters or grand daughters all they know about bringing up children and about the cause and treatment of diseases. This may be the reason why when these young mothers' children have diarrhoea they go to their mothers for advice, for as far as they are concerned their mothers know best what is best for their children.

The remaining eight point eight (8.8) percent of the mothers said they go to the traditional healer first when their children have diarrhoea before bringing them to the hospital. However, although some mothers expressed the wish to take their children to the traditional healer first, they took them to the hospital first because they had no money to pay the traditional healer for consultation and treatment. Many times a patient is brought to hospital with an illness that seems to have been neglected, probably because he has attempted to cure his illness with folk remedies (Hymovich et al, 1973). Many others feel the need to consult a traditional healer who they feel understands their problems

and background (Amonoo - Lartson, et al, 1984). Gelfand (1977) in agreement with Hymovich says that Africans though they have no real opposition to Western medicine they do more than merely take the drugs. He further writes that they always want to discover what spiritual agent caused the disease and they often hear them say that Western doctors have many valuable cures for diseases, ones even more powerful than their own but they do not understand some of their illnesses which can only be cured by their own traditional healer. Therefore, the Africans one can say do not find it worthwhile to go to the hospital if they have one of these diseases. This is unfortunate because it results in bringing the children with diarrhoea to the hospital late ^{and} in prostrated state.

However, Table 14 p. 27 indicates that 90 percent of the mothers brought their children to the hospital because the condition did not improve, most likely after trying other treatments. Simwanza (1984) had similar findings as well. The mothers had more faith in the curative powers of modern medicine as opposed to that of traditional healers and said they brought their children to the hospital because they felt their children would get the best treatment. Most mothers prefer to use modern treatment although they held traditional ideas as causes of diarrhoea. This may be due to the fact that many people especially those who are educated and have had positive experiences with modern health care practices of scientific medicine, allow their children to have professional care (Hymovich et al, 1973). Seven point five (7.5) percent brought their children to the hospital because they had been referred from the clinic health personnel and 2.5 percent did so because the child was dehydrated.

Table 15 p. 27 shows that 45 percent of the mothers had lost children, with 50 percent of the mothers losing one (1) child, 33.3 percent lost two (2) and 16.7 percent lost three (3) children each (Table 16. p. 27). Thirty-eight point nine (38.9) percent of the children died from diarrhoea and 16.7 percent from measles as shown in Table 17 p. 28. Other causes were malaria, pneumonia and

bleeding umbilical cord which were 11.1 percent each. Another 11.1 percent mothers' did not know the cause of death of their children. From this one can see that most children died from preventable causes. This may be attributed to the fact that most mothers brought their children late to the hospital such that the health personnel were not given enough time to treat the children successfully. In ^{developing} / communities, it is the children in particular who die and most commonly from diarrhoea, pneumonia, malnutrition, malaria, measles, whooping cough and tuberculosis (Byrne and Bennett, 1983).

Most of the children died between six (6) and ten (10) months old (38.9 percent). The other ages, eleven (11) to fifteen (15) months, sixteen (16) to twenty (20) months and twenty-one (21) to twenty-five (25) months were 11.1 percent each (Table 18 p. 28). Twenty-seven point eight (27.8) percent of the mothers did not know the ages of their children at the time of death. Most of the children died from diarrhoea when they were six (6) to ten (10) months old because diarrhoea is common in children between six (6) and twenty-four (24) months. Most children are weaned during this period because most mothers do not have sufficient milk. In case of a working mother who leaves the child with a nanny to bottle feed ^{the child} is prone to diarrhoea since the nanny does not understand the importance of cleanliness of the feeding utensils.

It was encouraging to learn that the majority of the mothers in the study (38 percent) breastfeed their children for long periods (18 - 20, 24 months and above, and 21 - 23 months respectively. Even the remaining 26 percent and 18 percent mothers breastfeed their children for reasonable periods 15 - 17 and 12 - 14 months respectively. (Table 19 p. 28). It was possible for most mothers in the study to breastfeed for a long time because they were full time housewives. The other reasons could be that mothers understand the importance of breastfeeding and so breastfeed their children for longer periods until they are big enough to be able to eat and benefit from the foods that adults eat.

However, the reasons given by mothers for stopping breastfeeding at this age were that, the mothers became pregnant and could not continue because the milk was bad. Others said at eighteen months the child was big enough to eat other types of food and some said they start to bite on the nipples when feeding.

Table 20 p. 29 shows that the majority of the respondents (70 percent) admitted that they give their children some medicine (mostly traditional) before they are brought to the hospital. Twenty-five (25) percent said they do not give their children medicine when they have diarrhoea and 5 percent said they give only if they have some diarrhoea treatment at home,

Sixty (60) percent of the respondents gave traditional medicine to their children when they had diarrhoea and before they were brought to the hospital and 20 percent gave traditional or modern medicine depending on what was available at home and what the mothers thought was the cause. Another 20 percent gave modern medicine to their children when they had diarrhoea before bringing them to the hospital (Table 20 p. 29). This shows that a good number of mothers still practice traditional customs and beliefs related to diarrhoea. Therefore, hypothesis number two (2), which says that most mothers' customs and beliefs regarding diarrhoea result in delay in bringing the children to the hospital and this makes it difficult to treat them successfully may be true. Furthermore, Table 21 p. 29 reveals that most medicines given to children with diarrhoea were prepared traditionally (76.7 percent responses).

In most cases the mother will get a kind of medicine from the traditional healer which she will boil and keep to use (Omari and Kitilia, 1976). The most common ways of preparing traditional medicine for treatment of diarrhoea is by pounding leaves or roots of certain trees (quava, mango and banana were mentioned as well), soaking or boiling them, then giving the fluids to children whenever he/she had a diarrhoeal motion. Dosage is not important as far as they are concerned what is important is the effect, so the more they give the better and the bitter

the fluid, the stronger and effective it is thought to be. It was observed that most mothers from the same tribe knew the same type of trees and method of preparation of traditional medicine for diarrhoea. However, one (1) woman did mention that she chews the leaves and spits it on the fontanelle of the child whenever she has diarrhoea. This any way would not have any effect on the child as such but the mother was sure that it works by stopping the fontanelle from depressing even when the child loses a lot of fluids through frequent diarrhoeing.

Thirteen point three (13.3) percent of the medicine was technically prepared and 10 percent did not know how it was prepared. These were the young women who did not even know what diarrhoea was.

Table 22 p. 29 shows the people who supplied the mothers with the medicines. Most mothers (32.7 percent) got the medicine from their neighbours. This is a common practice observed among mothers that when a child has diarrhoea and the mother does not have any medicine, she goes to the neighbours to ask for some. This means that she uses whatever medicine is available - traditional or modern. Twenty-six point nine (26.9) percent of the mothers said they knew the medicine themselves so that when their children have diarrhoea they prepare and administer it. This was traditional treatment, for example, pounding of guava or mango leaves, socking them and then giving the fluids to the child with diarrhoea. Thirteen point five (13.5) percent said they got the medicine from the Pharmacist. These were mothers who went to the hospital, clinic or private doctor. The remaining nine point six (9.6) percent got the medicine from the traditional healer. The African appreciates that a substance or a quality exists in a plant which is able to remove the problem in the body (Gelfand, 1977). It is this confidence and faith that most mothers have in the power of traditional medicine which makes them seek for it when their children have diarrhoea. Thus, many traditional customs and beliefs related to diarrhoea are being practiced today,

not only in rural areas but in urban areas as well. A good number of traditional healers are commonly seen in the townships and shanty compounds of urban Zambia.

The majority of mothers knew the effect of the medicine given to their children with diarrhoea as shown in Table 23. p. 30. Eighty (80) percent said it stops diarrhoea, 12.5 percent said it was to stop abdominal pains and others (7.5 percent) included to control diarrhoea, cleaning the stomach and 'killing' the germs in the body that are causing diarrhoea. It was observed that though the mothers did not know the actual dosage for the traditional medicine they were at least in the know how of its effects and when they did give it, it was for a good cause as far as they were concerned. This is why it becomes very important for the health personnel to consider traditional customs and beliefs related to diarrhoea when they are giving health education to the mothers on the condition because as far as the mothers are concerned there is nothing wrong with what they do.

Table 24 p. 30 shows that most mothers (77.5 percent) practice the health education regarding diarrhoea which is taught at the health centres, 7.5 percent said they practiced some of the things, 5 percent only practiced sometimes and ten (10) percent did not practice at all. The mothers who practiced some of the things taught, rationalised their action by saying that some of the things taught are not realistic and that only the things which they feel are of use to them and their family are practiced which means some mothers would prefer individual talks which would specifically consider their individual problems. This way they can concentrate and learn more from the health education talks. One of the mothers pointed out that health personnel talk about things in general terms, not really directing them to specific people. On the other hand, the mothers who did not practice what is taught said the health education talks are given hurriedly. Therefore, the sixth (6th) hypothesis which says most mothers do not put into practice the health education taught because it is contrary to their traditional customs and beliefs regarding diarrhoea may be accepted.

In conclusion, the findings reveal that most mothers know and practice traditional customs and beliefs related to causes and treatment of diarrhoea. Therefore, it is vital that health personnel realise the importance of these when giving health education talks on diarrhoea.

2. NURSING IMPLICATIONS

The findings revealed that most mothers knew some beliefs related to causes of diarrhoea and practiced them. It is therefore, important that health personnel take these into consideration when giving health education on diarrhoea prevention and control. The fact that this is being left out at the moment when health education is given, means health personnel are failing to get the message 'home'. Some mothers felt that individual talks are more beneficial or talks that are relevant to their problems rather than the general health education talks being given at the moment. Probably health personnel could consult the mothers and find out what they would want to know or learn and like wise give the talks accordingly. At the moment, the nurse decides on the topic to share with the mothers. Sometimes the same topic is discussed on four (4) consecutive visits that the mother makes to the clinic. This becomes monotonous to the mothers, they even lose interest. Also, when possible, health personnel should try and find time for individual talks especially for the few who need it. There are several hours in a week when the health centres are relatively quite; these are the times which should be used for individual teaching/counselling.

In their health education talks, health personnel should take into consideration the effects that the traditional customs and beliefs regarding diarrhoea in children may have on the child and the resultant delay in bringing the child to the hospital.

The findings also reveal that most of the children died from diarrhoea. Health personnel should emphasise to the mothers when advising them on diarrhoea the actual problem which is usually dehydration due to delay in bringing the child to the hospital. It should be emphasised to the mothers that bringing the children to the hospital early is very important so that the dehydration could be corrected immediately. Furthermore, most of the diseases that caused the deaths of the children could have been treated and thus prevented the deaths of the children.

Nurse educators too should emphasise to the students the importance of taking into consideration the traditional customs and beliefs related to diarrhoea and other diseases when giving health education talks, ^{this way they} will be more meaningful to most mothers. It is believed that the more nurses will understand the traditional customs and beliefs related to diarrhoea, the more they will be able to plan their advice appropriately.

Nurse administrators should make an effort to initiate research in their areas and stimulate their nurses to find out why there is an increase in morbidity and mortality rates of diarrhoea in their areas even when people are well aware about the condition. However, for this to be possible, there is need for basic research to be taught in basic nursing school programmes and in-service programmes. This will make nurses aware at an early stage and they will be reminded in future of the importance of research in their profession.

3. CONCLUSIONS

Clients need to be given an effective and appropriate health education on diarrhoea. The need for proper treatment education in relation to diarrhoea should be stressed. The findings have shown that most mothers gave traditional treatment before bringing the children to the hospital. Though this traditional treatment of diarrhoea may sometime mean that dehydration is lessened, the child is at risk

of having a serious illness from the effect of the medication especially when the same treatment is prolonged. The medicines are not scientifically proven and therefore can lead to herbal toxicity in the child. Furthermore infective diarrhoea may not be cured with traditional medicines as it only responds very well to antibiotics.

The intergration of traditional medicines (after it has been proven scientifically effective and dosages ascertained) with modern medical practice would be the best prescription especially when the country's limited manpower, finance and economic resources are taken into account. If this is done, it would also facilitate the two way communication between traditional and modern healers and will eliminate the mutual suspicious attitudes especially towards traditional medicine for diarrhoea which has been built up all these decades. Thus, basing health education on diarrhoea on identified beneficial or good traditional customs and beliefs is very important if health personnel are to control and prevent diarrhoea in Zambia where the majority of the people still adhere to their culture.

4. RECOMMENDATIONS

1. A study of this nature should be conducted on a large scale so that generalisation of findings can be made and it should be done during the hot season when there are many children admitted with diarrhoea.
2. Emphasis should be made in the training institutions for health personnel on the role of the clients' traditional customs and beliefs regarding diarrhoea or any other disease. This will make it possible for health personnel to give realistic, effective and appropriate health education especially to those who strongly adhere to them.
3. Health personnel should give individualised patient teaching and different topics should be discussed. This is very important because the teaching will be more meaningful to the clientele and they will benefit more from it, since it will concentrate only on their individual problems.

4. Health personnel should evaluate the effectiveness of the health education given to the mothers on diarrhoea prevention and control in their catchment area at least monthly. This will help health personnel to know whether the behaviour of the clientele through health education is changing positively towards health practices or not. It will help them know whether the clientele are practicing what they are taught or not.
5. Studies should be conducted in the different Provinces of the country by the health personnel working in the respective Provinces and try to identify the traditional customs and beliefs related to diarrhoea so that the good ones could be identified and incorporated in the health education talks and bad ones could be discouraged.
6. Health workers should assist in establishment of diarrhoea control committees at ward, section and village levels involving influential members of the society in each setting. This would be successful especially in high density areas where the party seems to be actively organised.

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

27 January 1986

The Unit Nursing Officer,
University Teaching Hospital,
Paediatric Unit,
P.O. Box 50001,
LUSAKA.

Dear Madam,

Subject: STUDY PROJECT

I am a student at the University of Zambia School of Medicine in the Post-Basic Nursing Department. I am currently pursuing a degree for the Bachelor of Science in Nursing majoring in Community Health Nursing. I am required to submit a research study in my speciality areas as part of the course requirements. My research topic is: Mothers' traditional customs and beliefs related to diarrhoea in children who are admitted to U.T.H.

I would be very grateful if you would kindly grant me permission to visit the wards and interview fifty (50) mothers in Ward A06. This will enable me to collect information required for the study. The collection of data will be between the third (3) week of February and the end of March 1986.

It is hoped that the study will benefit the nurses and patients as the study will determine the mothers' traditional customs and beliefs and the extent to which they influence the mothers' reactions to diarrhoea in children. The nurses will also be able to give appropriate and efficient health education on the condition.

Thanking you in anticipation.

Yours faithfully,

Catherine C. Chime (Miss)

c.c. The Executive Director
U.T.H. Board of Management
LUSAKA

The Principal Nursing Officer
U.T.H.
P.O. Box 50001
LUSAKA



University Teaching Hospital,
Department of Paediatrics & Child Health,
P.O. Box 50001,
LUSAKA

29th January, 1986.

Miss Catherine C. Chime,
Department of Post Basic Nursing,
School of Medicine,
P.O. Box 50110,
LUSAKA.

Dear Madam,

RE: RESEARCH PROJECT

I refer to your letter regarding your request for permission to carry out research project in our department.

I am pleased to inform you that you are welcome.

In order to make your work easy, please report to the office of the Matron so that, you can be introduced to the areas of your needs.

Wishing you all the success in your project.

Yours faithfully,

M.K. Chisembele
ACTING NURSING OFFICER

INTERVIEW SCHEDULENUMBER

1. How old are you?

1. 15 - 19 years

2. 20 - 24 years

3. 25 - 29 years

4. 30 - 34 years

5. 35 - 39 years

6. 40 + years

1

2. What is your educational attainment?

1. None

2. Grade 1 - 4

3. Grade 5 - 7

4. Grade 8 - 9

5. Grade 10 - 12

6. College

2

3. What is your occupation?

3

4

5

4. Where do you live?

1. Low density

2. Medium density

3. High density

6

5. What is your tribe?

7

8

9

10

6. What is your marital status?

1. Married
2. Single
3. Divorced
4. Widowed
5. Separated

11

7. How many children do you have?

1. 1 - 3
2. 4 - 6
3. 7 - 9
4. 10 - 12
5. 13 +

12

8. a) Have you lost any children

1. Yes
2. No

b) How many?

c) What did they die of?

13

- 1.
- 2.
- 3.
- 4.

14

15

16

17

9. Where do you normally delivery your children?

22

23

10. For how long do you breastfeed your children?

24

11. How old is the admitted child?

25

12. For how many days has the child been having diarrhoea?

26

13. What is diarrhoea?

27

28

29

30

14. What are the causes of diarrhoea?

1.

31

32

3.

33

4.

34

15. a) What do you do when your child is having diarrhoea?

1.

35

2.

36

3.

37

4.

38

5.

39

b) Do you give the child some medicine before bringing him to the hospital?

40

c) What kind of medicine?

41

42

d) How is it prepared?

43

e) Who gives you the medicine?

44

f) What are you told about the medicine in relation to diarrhoea?

1.

45

2.

46

16. What makes you decide to bring the child to hospital?

1.

47

2.

48

3.

49

4.

50

17. Do you practice the health education regarding diarrhoea which is taught at the health centre?

51

Thank you for your time and cooperation.

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