

A Study on Knowledge and Practice of Urban and Rural Parents Regarding Home Care of Children during Diarrhoea

By

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**A research report submitted in partial fulfillment of the requirement for
the bachelor degree of hospital nursing**

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A STUDY ON KNOWLEDGE AND PRACTICE OF URBAN AND
RURAL PARENTS REGARDING HOME CARE OF CHILDREN
DURING DIARRHOEA IN KANTI CHILDREN HOSPITAL

A RESEARCH REPORT

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Bachelor degree in hospital nursing

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ABSTRACT

This comparative, exploratory type of study was adopted to measure the knowledge and practice about care of children under five during diarrhoea between Urban and Rural parents for partial fulfillment of requirement for Bachelor degree in Nursing.

The objectives of this Study was to compare the knowledge and practice between Urban and rural parents regarding home care of under 5 children during diarrhea. The area of the study was Medical OPD of Kanti Children Hospital.

A combination of closed and semi structured questionnaire was used for the interview of the subject after maintaining validity and reliability. Data was collected by investigator herself and obtained data were analyzed by using statistical tools or formulas. A quota sampling method was used to select the 50 samples.

Major findings drawn from the study shows that diarrhoea was predominantly seen in male children both in Urban (68%) and rural (76%) areas. Diarrhoea was seen in age between 6 months to 2 years both in Urban (40%) and in rural (60%) children. Most of the children were suffered from mild dehydration both in (64%) Urban children and (80%) in rural children. Majority of respondents were mother both in Urban (88%) children and rural (88%). And majority of mother were age group between 20-24 years both in Urban and Rural majority of respondents were literate both in Urban (72%) and (80%) in rural. Majority of the respondents in both areas were housewives, 76% in Urban and 84% in rural. Majority of respondents had one child both in Urban and rural. Majority of respondents (52%) in Urban areas had satisfactory economic status but (56%) of rural respondents had poor economic condition.

Majority of respondents, 76% in Urban and 60% in rural respondents knew the causes and meaning of diarrhoea. 80% & 80% of respondents in both areas stated that under 5 children are most risk for diarrhoea. 72% of urban respondents stated that diarrhoea is communicable where as 64% of rural respondents stated that diarrhoea is not communicable. 52% of rural parents stated that diarrhoea is dangerous disease but 48% of urban parents stated that diarrhoea is both (simple + dangerous) diseases. 76% and 76% of Urban and rural parents stated that diarrhoea is preventable by the proper sanitation, hygiene and by using boiled water. Cent percentage of Urban and rural parents stated that food is better during diarrhoea, among them cent percent parents of Urban and 96% of parents of rural stated that liquid food is better during diarrhoea. 68% of rural parents and 60% of urban parents had not knowledge regarding dangerous complication of diarrhoea. 88% of urban respondents stated that Dal Ko Jhol is better during diarrhoea whereas 72% of rural respondents stated that Gedagudi Ko Jhol is better during diarrhoea. 96% of urban respondents and 92% of rural respondents had knowledge regarding jeevanjal.

Cent percent of urban respondents and 92% of rural respondents were giving additional water, among them. 80% of urban respondents had given jeevanjal but 56% of rural respondents had given plain water during diarrhoea. 60% of urban respondents and 50% rural respondents were giving fluid correctly. 92% rural respondents and 84% urban respondents were breast-feeding then continuous in diarrhoea. 92% urban parents and 76% rural parents were giving food during diarrhoea, among them cent percent of respondents in Urban and 78.94% of rural respondents were giving Jaulo to their children during diarrhoea. 88% of urban respondents and 84% of rural respondents were disposing his/her child's diarrhoeal excreta in toilet. Cent percent of Urban and rural parents were cleaning the child's buttock after each defecation. Cent percent of Urban and rural parents were hand washing after disposing child's diarrhoeal excreta among them cent percent of urban parents and 92% of rural parents were used soap and water for hand washing. 64% of rural children and 56% of urban children were checked to other before came to the hospital.

The conclusion of this study is that the majority of urban and rural parents have adequate knowledge and positive practice about care of children during diarrhoea and also this results indicate that knowledge and practice of rural parents not poor in relation to urban parents. It might have been due to educational status, facilities of communication; transportation and residential area because most of rural parents were from Kathmandu valley than out of valley.

This study recommends that the problems of diarrhoea should be controlled and cured by using of adequate oral rehydration solution and others liquids. And this study also recommends that the health education still needed about "danger signs of diarrhoea" because majority of urban and rural parents have not knowledge regarding it.

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CHAPTER – I

INTRODUCTION:

1.1: -Background of the study:

Nepal has an area of 1,47,181 Sq. Kms. Total population of Nepal is 2,31,51,423 according to National census of 2001. Nepal is a developing country and its more than two third of total population are live below the poverty. Education, Sanitation and drinking water supply play vital role for maintaining the health of the people. But the literacy rate of Nepal is very low i.e. (53.74%). Only (71%) of the total population has access to safe drinking water (Statistical health information bulletin, 2002) and about (16%) of the total population has access to sanitation facilities.

Therefore these various factors are the causes of high diarrhoeal incidence in Nepal. Diarrhoeal disease is one of the major public health problems. According to HMIS report for the fiscal year 2000/2001 (July to June), among the total number of children under five years, 267 children have been recorded to death due to only diarrhoea. According to HMIS report, the incidence of diarrhoea was 164/1000 children in the year 1999/2000 and 172/1000 children for the year 2000/2001. Although its incidence is reducing, it is far from satisfactory level

Care of diarrhoea at home is very necessary because proper feeding, adequate dehydration fluid, continuous breast feeding, proper hand washing and proper disposal of diarrhoeal excreta etc can treat many of the children during diarrhoea at home. Proper care during diarrhoea provides the child with the nutrients needed for growth and prevent weight losses, dehydration and malnutrition. The maintenance of fluid and electrolyte balance and provision of adequate nutrition are important measures in the management of diarrhoea at home.

So, the national diarrhoeal disease control programme has been accorded a priority status by HMG and shall remain an integral part of primary health care. Improvement in diarrhoeal case management will be used as a primary strategy for reduction of mortality due to diarrhoea among children under five years. But the non-equality of development of Urban and rural areas of country has predisposed the people of rural areas to have many problems than the people of urban areas. The people of Urban areas have so many facilities like communication by different media eg.TV, Radio, FMs, Newspaper, etc. ,electricity, transportation, safe drinking water. These facilities are improving the knowledge and practice of urban parents during diarrhoea. But more people of the country live in rural areas. Total rural areas are surrounded by three major problems like communication, transportation and education. So, lack of these facilities may caused wrong practice and parents have tendency of withholding food or to provide inadequate food and fluid which can lead to life threatening dehydration and malnutrition during diarrhoea. Hence, the aim of this study to compare the care of parents between Urban and rural areas and to find out the deficiencies which will help in providing appropriate health education about the” Home Management of Diarrhoea” to the parents of under five children.

1.2: Rational for the study:

A majority of Nepalese parents are illiterate and ignorant and they live in rural areas of the country. The literacy rate of Nepalese people is only 53.74%. Among this, the literacy rate of female is also very low. The parents have not adequate knowledge and proper practice about home care during diarrhoea. Diarrhoeal disease is a major public health problem and a major contributor to malnutrition. According to Adhikari(1997) a child under five years of age suffers from 4-6 episodes of diarrhoea every year in Nepal. Similarly, Diarrhoeal disease is one of the main causes of death among children. Death from diarrhoea is often associated with malnutrition.

So, it is useful to determine the knowledge and practice of parents about care during diarrhoea because parents (specially mother) are the first care provider for any disease of their child, particularly for diarrhoea it is most necessary and important to provide food, fluid and also most important to dispose diarrhoeal excreta properly.

1.3: Significance of the study:

Especially in under five years children, there is higher incidence of diarrhoea. Diarrhoea is a major health problem of children in developing countries like Nepal. The researcher think that this study would be useful, because:

- This study would be helpful in finding out the current knowledge about meaning of diarrhoea, its causes, complication, Jeevanjal preparation, and food during diarrhoea, fluid during diarrhoea, and practice of cleaning the Childs buttock between Urban and rural parents.
- This study will be helpful in finding out existing practice e.g. Prevent from dehydration, fluid during diarrhoea, cleaning the child's buttock between Urban and rural parents.
- The findings of the study would be helpful to the health personnel to give emphasis planning in more appropriate health education about feeding, Jeevanjal preparation, proper disposal of excreta, importance of hand washing and sanitation etc. which helps to reduce the dehydration and malnutrition.
- This study would help the researcher for further study.

1.4: Objectives of the study:

General objectives: -

To compare the knowledge and practice of urban and rural parents regarding home care of under five children during diarrhoea.

Specific objectives: -

- * To compare the knowledge of urban and rural parents about meaning, causes and most risk person for diarrhoea.
- * To compare the knowledge of urban and rural parents about types and patterns of food and fluid to be given during diarrhoea.
- * To compare the knowledge of urban and rural parents about preparation of oral rehydration solution (Jeevanjal).
- * To compare the knowledge of urban and rural parents about danger complication of diarrhoea.
- * To compare the practice of urban and rural parents about additional food and fluid given during diarrhoea.
- * To compare the practice of urban and rural parents about frequency of fluid and food given during diarrhoea.
- * To compare the practice of urban and rural parents about breast-feeding patterns during diarrhoea.
- * To compare the practice of urban and rural parents about disposal of child's diarrhoeal excreta, cleaning the child's buttock after diarrhoea and hand washing technique.
- * To recognize measures to improve the parents practice regarding home care of under five children during diarrhoea at home.

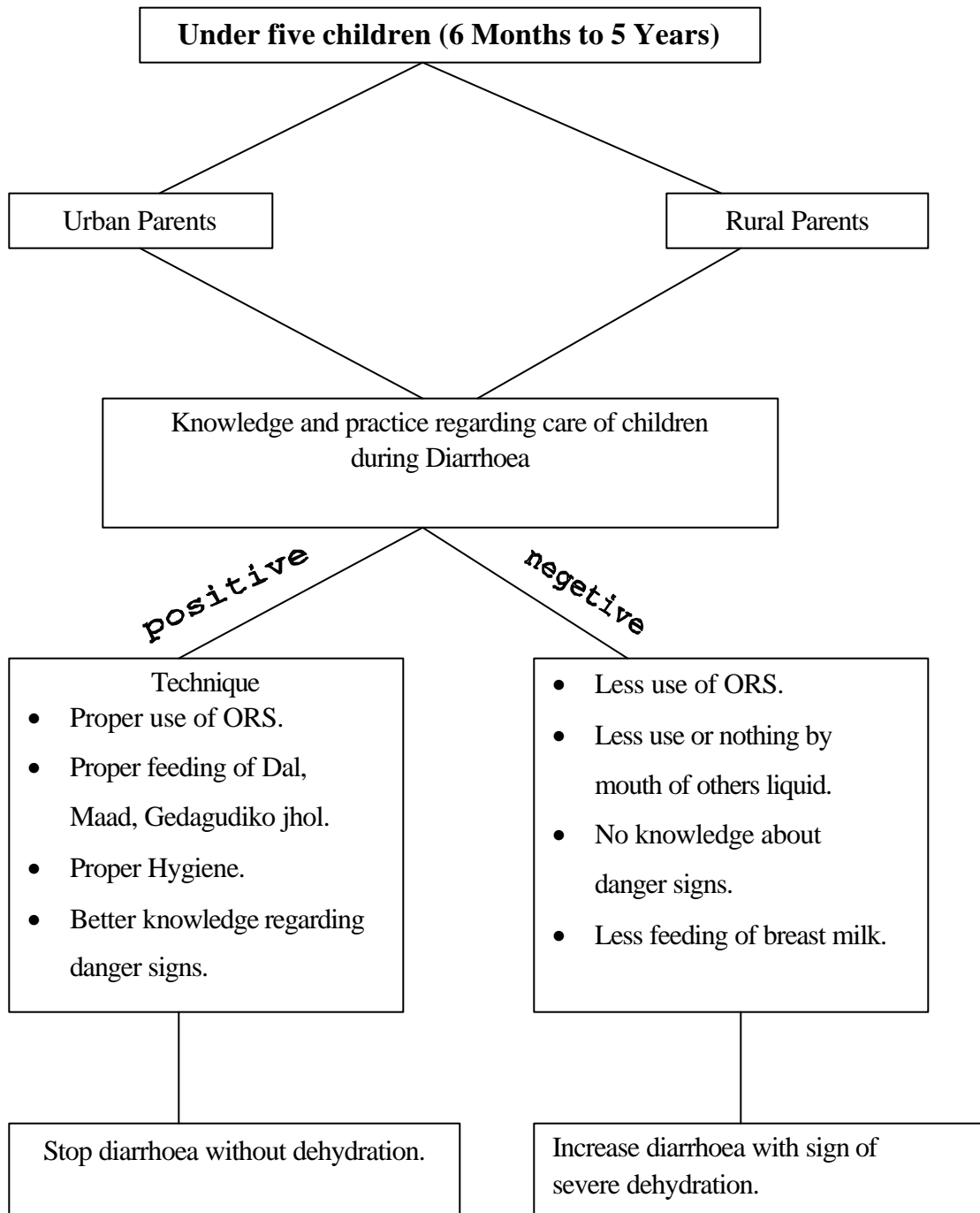
1.5: Hypothesis of the study: -

Knowledge and practice regarding home care of children during diarrhoea would be better in urban parents than in rural parents.

1.6: Operational definition: -

- * **Knowledge:** - Knowing about meaning of diarrhoea, its causes, risk person, complication, additional food and fluid,,preparation of Jeevanjal,,danger complication Of diarrhoea etc.
- * **Practice:**-It refers to the way of doing that is common or habitual.
- * **Under five children:** - Children in age group of 6 months to 5 years.
- * **Urban area:** -People belonging to semi-nagar palika,nagar palika,and mahanagar palika.
- * **Rural area:** -People belonging to VDC and interior of the country.
- * **Home care:** -Care at home.

1.7: Conceptual framework:-



1.8: Variables:-

***Independent variable:**

- Parental age.
- Parents' education.
- Parents' occupations.
- Economic status.
- Residence.
- Gender of parents.
- Number of children.
- Past experience.

***Dependent variables:**

- Knowledge and practice of parents regarding the care of children with diarrhoea.

1.9: Strength & Limitation of the study:

Strength:

- Investigator received sufficient cooperation from concern authority & parents of under five children in the study setting.
- This study tried to explore current knowledge & practice of parents about home management of children during diarrhoea.
- Interview questionnaire was pre-tested for validity & reliability.
- The researcher own self collected data, which reduce the risk of misleading the findings.

Limitations:

- This small study could not be generalized because this study was limited to only 50 parents of under children with diarrhoea who were attended kanti children hospital for the management of diarrhoea & mild diarrhoeal cases might have been missed.
- Practice data was also obtained by interview questionnaire, so findings of the study is depend upon the respondent's honesty.

1.10: Difficulties faced during the study

- Lack of literature related to the study.
- Difficult to maintain privacy of parents in medical O.P.D.
- Investigator felt difficult to take the information at first because parents were worried about his/her children. So she reassured them first & gave wanted information, then information was taken about the study, so that too much time spent.

1.11: Plan of dissemination

- Nepal Health Research Council
- Research advisor
- Library or the Maharajgunj Nursing Campus
- Kanti Children Hospital
- Researcher herself.

CHAPTER – II

2. REVIEW OF LITERATURE:

This chapter presents a review of literature, which were reviewed both research as well as non-research areas of books, journals, documents and also searched in the Internet.

The reviewed literatures are presented as following: -

2.1.Introduction of Diarrhoea:

1. In general, diarrhoea is defined as the passage of liquid stool in increase number and volume. There may be changes in the colour and smell of the stool too. When blood and mucus is seen in the stool along with abdominal cramps and tenesmus the condition is called dysentery. When diarrhoea is associated with vomiting and with or without fever, it is called gastroenteritis.
2. Janet Zand L.Ac., OMD (health world outline, 2000), reported that diarrhoea, or frequent and watery stools, is the body's way of ridding itself of toxins and foreign substances. Most cases of simple diarrhoea should not be suppressed too quickly. It may be healthier to allow child's body to flush itself clean while supporting her with adequate fluids (4)

2.2: Incidence and prevalence of diarrhoea:

- (1) Department of health services (DHS) epidemiology and diseases control division (1999), stated that diarrhoeal diseases are one of the major causes of deaths and malnutrition in Nepal. Within first 6 month of child life he/she experiences 3.3 episodes per year resulting in about 30,000 deaths annually. In addition to that these repeated attacks of diarrhoea are major causes of malnutrition and faltering height and weight. Malnourished children also suffer more severe attack of diarrhoea and hence higher mortality. Diarrhoeal disease caused more than 3million deaths in 1995 (80% in <5 children) and about 50% of these death are due to acute watery diarrhoea.(16)
- (2) Adhikari (1997), reported that diarrhoeal disease is one of the most important child health problems in the developing countries. According to one of the estimates, a child under five year of age suffers from 4-6 episodes of diarrhoea every year in Nepal. Similarly, diarrhoeal disease is one of the main causes of death among children. (25)

One study is carried out by Babaniyi OA, et al, 1994, about management of diarrhoea at the house hold level, in Nigeria. Home management of diarrhoea was studied in 1,638 children under five year of age whose 1,160 mother they randomly selected in suleja local government area in November 1991. The estimated annual incidence rate of diarrhoea disease was 4.6 episodes per child. Prevalence of diarrhoea during the

two preceding weeks was 20.8%, 73.8% of the cases were in children under two years of age.

2.3: Predisposing factors:

1. Contributing factors of diarrhoea are age, seasons, nutrition status, Socio-economic status and feeding.

* **Age:-**It is more common in children under the age of two years.

* **Season:-**It is more common in pre-monsoon and monsoon period.

* **Nutrition status:** -Malnourished children are more prone to diarrhoeal disease due to reduce body resistance to infection.

* **Socio-economic status:-**It is more common in low socioeconomic group due to Ignorance and poor personnel hygiene and environmental sanitation.

* **Feeding:-**Incidence of diarrhoea low in breast-fed babies. Whereas it is high in Bottle-fed babies. (27)

2. Adhikari 1997, stated that inappropriate supplementary feeding, early introduction of supplementary feeding, unhygienic living condition, improper disposal of waste and excreta, use of contaminated water to age between six months and two years are predisposing factors which make the child more likely to suffer from diarrhoea. (25)

3. Incidence, mortality and morbidity of acute diarrhoea depend to a large extent to the feeding habit of infants and children. In a study done by Cesar, G. Victoria et al, the association between infants feeding habits and infants mortality from diarrhoea was investigated in a population based case control study in two Urban areas in southern Brazil during 1985. Each of 170 infants who died due to diarrhoea was compared with two neighborhood controls. After allowance was made for confounding variables, infants who received powdered milk or cows milk in addition to breast milk where at 4.2 times (95% confidence interval 1.7-10.1) the risk of diarrhoea compared with infants who did not receive artificial milk, while the risk for infants who did not receive any breast milk was 14.2 times higher (95% CI 5.9-34.1%). Infants who received powdered milk only were found to be at slightly higher risk than those who received cows milk only, but the difference was not statistically significant.

4. Oni (1996), reported that socio-economic condition and feeding practice related to diarrhoeal disease among infants. Five factors had significant association with diarrhoeal disease. These are the age of child, parity, and mother's education, availability of household's kitchen and feeding of semisolid food to the infants. The lowest diarrhoeal rate occurred in infants aged 0-3 months while the highest rate occurred among infants 7-9 months old. Children who were of the fifth or higher birth order had significantly higher risk of diarrhoea when compared with those who

were of the first & second birth order. Children of mother with secondary education had significantly higher risk of diarrhoea compared with children illiterates. (14)

5. Al-Mazrou et al. (1995) stated that the social factors influence diarrhoeal prevalence rates. The factor associated with higher prevalence rate were the children of youngest (15-19 years old) mother (28%), the children aged 6-17 months 24%-31% and rate in those who lived in rural setting was higher (15%) than in those who lived in Urban setting (14%). (9)
6. Ribeiro H Jr. 2000, stated that infants and young children from many developing nations face a serious public health threat from diarrhoea. In the northeast region of Brazil, diarrhoeal disease cause significant morbidity and mortality. Although diarrhoeal deaths in this region have been decline since the early 1980s, the hospitalization rate remains high. Diarrhoea may account for 25% of total health care costs in northeast Brazil. Many patients become ill because of poor environmental condition and because their caregivers lack awareness of basic hygiene.
7. Mock et al. (1993), stated that male children had a more than two fold odds of experiencing recent diarrhoea than did female children among those greater than one years of age, children under one years of age who were already weaned had a greater odds of disease than those who were still breast fed, and Urban residence also was highly associated with diarrhoeal disease occurrence. Urban residence is likely to reflect a host of socio-economic, environmental and behavioral factors. (13)
8. The incidence of diarrhoea is increased during measles during the 4 weeks following the illness and probably for up to 6 months after the measles episodes. Measles associated diarrhoea is often severe and of longer than usual duration, the risk of death is also substantially higher than with diarrhoea that is not related to measles and is probably even greater when children are also malnourished. Where the incidence of measles is high, measles associated diarrhoea can account for one third or more of diarrhoea-associated deaths in young children. Immunization against measles is therefore an important measure for preventing both diarrhoeal episodes and diarrhoea-associated death in young children.
9. The most important risk factors for diarrhea-associated death in infants and young children are severe malnutrition, co-existence sepsis, shigella infections, hypoalbuminemia and metabolic acidosis. In addition to electrolyte and fluid treatments, prevention of malnutrition, promotion of breast-feeding are very important to reduce fatality rates of diarrhoeal diseases. Besides feeding during diarrhoea is important because it lessens weight loss and also may prevent fatal hypoglycemia. (5)
10. Numerous studies have been done to identify environmental and personal hygiene practices and risk factors for diarrhoea. In one study by Oyemade Adefunke et al., cross sectional study was carried out in Nigeria to determine the environmental and personal hygiene practices of mothers of children aged less than five years in two markets in Ibadan. One with poor sanitation condition (Bodija) and the other on

better sanitation facilities (Ghagi). Occurrence of diarrhoea was highest among the children of mothers who brought water from the market and lowest among those who used tap water ($P<0.05$). Diarrhoea was more prevalent among the children of mothers who brought their breakfast and lunch from the market food vendors compared to those who prepared it at home ($p<0.05$). Diarrhoea occurred more among the children who defecated in open spaces for example on the spots or in the bush compare to these who defecated in designated places ($p<0.05$). Diarrhoea was more prevalent among the children of mothers who washed their hands with water only than those who washed their hands with soap and water. Children of mothers with poor refuse disposal practices recorded the incidence of diarrhoea more ($p<0.05$).

11. In other study conducted by Shrestha, et al. In Bungmati village panchayat of Lalitpur district to determine incidence, practice and beliefs of mothers about diarrhoea. The study population composed of 968 mothers with children below the age of five years. The study showed 45.7% of the mother believed that cause was related to food, 35% thought that fluid should not be given to the children during diarrhoea, 67.2% mothers thought that less food or no food should be given to children during diarrhoea, 62.3% of the mothers had heard about the ORS and only 33.5% could prepare it correctly. It was encouraging to rate that 82.74% of mothers were continuing breast-feeding during diarrhoea.

12. Vitamin A deficiency also causes increased incidence, morbidity and mortality due to diarrhoea. A study carried out by Nepal Nutrition Intervention Project-Sarlahi (NNIPS) vitamin A supplementation community trial (NNIPS-1), diarrhoea related mortality rate was drastically reduced in vitamin A supplemented children as compared to children not supplemented with vitamin. In other study conducted by Somer et al, in Indonesia, the comparison of overall mortality rates showed mortality to be 34% lower among children 12-71 months of age in the 229 village receiving the supplement of 200,000 IU of vitamin A twice a year than those in the 221 control villages not received vitamin A supplementation.

2.4: Management of Diarrhoea by Food and Fluid.

1. By Fluid:

- All children with diarrhoea need extra fluids to prevent dehydration as soon as the diarrhoea starts. Give fluid as much as the child will take, most fluids that a child normally takes can also be used for home therapy. Those promoted however, should be ones the mother would agree to give in large amounts be readily available and affordable. Suitable fluid includes:

- ORS solution
- Food-based fluids (such as soup, rice water and young fruit drinks or clean water)
- Fruit Juice
- Sweetened fruit drinks and tea & coffee should be avoided as these can worsen diarrhoeas.

In addition to the normal fluid intake after each loose stool or vomit give:

* A quarter to half of a large cup of fluid (50-100ml) for children < 2 years.

* A half to one large cup of fluid (100-200ml) for children 2 years or above.

Tell the mother to give frequent small sips from a cup. If the child vomits, wait 10 minutes and then give more slowly. She should continue giving extra fluid until the diarrhoea stops. (17, 19)

•Ali et al (2000) have reported that the use of oral rehydration therapy for management of children diarrhoea in rural Bangladesh was inadequate. Common reasons for not using ORS included misperception about diarrhoea and age of patients. Other reasons included incorrect assessments, severity and difficulties with the administration of oral rehydration solution. Promotion of ORT can be effected by improving the level of understanding of mothers with regard to assessment of severity, early initiation of treatment regardless of age, sex, type of diarrhoea, breast feeding and nutrition status. (8)

•Ahmed et al. (2002), have studied and reported on the mother's skill in preparing Rehydration salt solution. A total of 420 mothers whose children have been suffering from acute diarrhoea were investigated. The study findings indicated that only one-third mothers 140 (33.3%) were able to prepare the packet of ORS solution correctly and the rest of the 237 (56.4%) mothers prepared the solution incorrectly, which were either concentrated or diluted. The intake of concentrated solution may give rise to life threatening hypernatremia, and diluted solution in respect to sodium may give rise to hyponatremia. The children also refused the incorrectly prepared ORS solution resulting in over all less intake of ORS solution. This inadequate preparation and intake of ORS hampers the prevention and treatment of dehydration and contributes to mortality and morbidity due to diarrhoeal diseases. (4)

•Sharma 1998 reported that home fluid composition is not as appropriate as that of ORS solution for treating dehydration, other fluids such as soup, rice water, youghurt drinks or plain water may be more practical and nearly as effective for oral rehydration therapy to prevent dehydration. These home fluids should be given to children to drink as soon as diarrhoea starts, with the goal of giving more fluids than usual. Feeding also should be continued. Such early home therapy can prevent many patients from becoming dehydrated and it also facilitates continued feeding by restoring appetite. (26)

•ORS solution is the treatment of choice for the patients with some dehydration. This formula for oral rehydration salt (ORS) recommended by WHO and UNICEF. A family member should always be shown how to prepare and give ORS solution. It is important that ORS should be prepared correctly i.e. with correct volume of water (1 liter of 6 glass or 2 mana), putting in all the contents of the packet and mixing it properly. The solution should be given to the infants and young children using a clean cup and a spoon. Children under 2 years of age should be offered a teaspoonful every 1-2 minutes. Older children and adults may take frequent sips directly from the cup. When Properly prepared and administered ORS solution provides adequate quantities of electrolytes to correct the deficits associated with acute diarrhoea. The

presence of potassium in the solution is important in view of the large potassium losses associated with acute diarrhoea, especially in infants. ORS also correct the base deficit acidosis. This is true irrespective of the cause of the diarrhoea and forms the physiological basis of oral rehydration therapy using ORS solution. (17)

- Yadav and Singh (1997) have carried out the comparative study about the efficacy of home made raise water salts (RWS) solution with oral rehydration solution (ORS). Each solution was given to 60 randomly selected under 5 year children suffering from acute watery diarrhoea and efficacy was judged from time for initial rehydration, amount of solution consumed during the first 24 hours, and the number of days required for passing of normal stools. It shows that majority of patients of RWS solution had passed normal stool on the second day of the therapy respectively. So this data shows that RWS solution is more effective in managing acute watery diarrhoea. (7)

- According to Adhikari (1997), Rice powder can be used instead of sugar. Its use has been found to be more beneficial in preventing dehydration and malnutrition following diarrhoea. This is prepared as follows.

- a) Place one teaspoonful of rice powder in a cooking pot.
- b) Measure out one Mana or three full tea glasses (half liter) of water. Slowly mix some of the water in to the rice powder until it is well blended.
Then add the rest of the water.
- c) Cook the mixture until it has the appearance of rice water.
- d) Add one three finger pinch of salt and mix well.
- e) Cool until it is easy to drink.

A child with diarrhoea and non sign of dehydration should be fed with rice ORS at a Rate of 50ml/kg over a period of four hours.

- Nepal multiple indicator surveillance (1996) reported that the timing of fluid is all-important. A child given fluid on the first day of illness has less than one half the risk of long duration diarrhoea compared with the child not given fluids on the first day. A child of a literate mother is 50% more likely to have a short duration diarrhoea, when compared with a child of an illiterate mother. Literate mothers are more likely to give fluids promptly, but this does not explain the shorter duration of diarrhoea. There are evidently some other factors related to literacy other than these specific actions. (18)

- According to National diarrhoea disease control program HMG/NEPAL (1996), 17% of children in under 5 age group as having diarrhoea in the last 2 weeks. Of these 35% were found to have used ORS. Throughout the awareness about the use of ORS or Jeevanjal has gone up considerably, the use is still lower. Even among the users of ORS are inputting in too little water followed by putting in the partial content of the packet and not dissolving it properly. It also shows 47% of the episodes not

receiving any liquid and 18% of the episodes were withhold food while 65% received lesser than normal amount. (17)

- If the child is being breastfed, and children with diarrhoea should be breastfed more frequently and for longer at each feed. If the child is exclusively breastfed, give ORS solution or clean water in addition to breast milk. After the diarrhoea stops, exclusive breast-feeding should be resumed. For infants who are not breastfed, the usual milk feed (or formula) should be given at least every 3 hours, except during 3-4 hours rehydration period. However if they are under 6 months of age and not yet taking soft food, the usual milk should be diluted with an equal amount of water for 2 days. For children 6 months or older or who are already taking soft foods, dilution of milk is not necessary. (17,19)

- Adhikari (1997), He also stated that mother may be worried by the increased volume of stools following the feeds and may stop feeding. The mothers will have to be reassured that the child will recover fast if the feeding is continued.(25)

- For the vast majority of children with diarrhoea, the routine dilution of milk or the use of lactose free milk is not necessary, especially when oral rehydration therapy is given and feeding is resumed early. Only severely malnourished children, children with diarrhoea lasting 14 days or more, or those whose diarrhoea worse after drinking animal or formula milk may need diets containing less lactose. The results from this large and carefully analyzed study should be useful to health workers managing non-breast fed children with diarrhoea. (22)

- In one study carried out by Subedi, B.K., he tried to reveal the knowledge, attitude and practices in diarrhoeal diseases in Baitadi. In the study 54.8% do not think diarrhoea is a self-limiting diseases. Though food and fluid restrictions are considered the best treatment by only 1.42%, the attitude towards food and fluid restriction is high (42.8%) for food and 25.5% for fluid, and the practice of food and fluid restriction is even higher; 18.3% do not give food and fluid during diarrhoea and 32.7% practice food and fludes restriction as a method of home treatment. 34.6% consider drugs in dry form the best treatment for diarrhoea and ORS is considered best by 22.62% but practiced at home by only 9.12%. Dehydration as a cause of death was mentioned by only 10.1%.

2.5: Management by food.

- One study carried out by Nishimura, Mayami on ORT unit in Kanti Children Hospital, 100 mothers of the children with diarrhoea were interviewed. In the study 21% mothers did not gave any food to the children because the children refuse to eat whereas 16% mothers never provided food to the children thinking it would be harmful to the children.

- There is strong interaction between diarrhoea and under nutrition during diarrhoea,decreased nutrient absorption and increased nutrient requirements often combine to cause weight loss and failure to grow; the child's nutritional status

declines and any pre-existing under nutrition is made worse. In turn, under nutrition contributes to diarrhoea, the illness being more severe, prolonged, and possibly more frequent in undernourished children. This vicious circle can be broken by:

- Continuing to give nutrient rich foods during diarrhoea, and
- Increasing food intake after diarrhoea stops.

Food intake should never be restricted during or following diarrhoea continued sufficient nutrient are usually absorbed to support continued growth and weight gain. Continued feeding also speeds the recovery of normal intestinal functions, weight, including the ability to digest and absorb various nutrients. In contrast, children whose food is restricted or diluted usually lose weight have diarrhoea of longer duration and recover intestinal function more slowly.

- Janet Zand (2001) reported that, diarrhoea eliminates foods that are difficult to digest. Protein should be avoided for about forty-eight hours. Fat should be eliminated from the diet during any illness. They are difficult even for a healthy body to digest and a distressed intestinal track makes it even harder. Undigested fats, contribute to a toxic internal environment. Eliminate refined sugars especially if the child's diarrhoea is bacterial in origin. Bacteria thrive in the presence of sugar. Sugar also makes the body more acidic.
- Sullivan (1998), reported that despite recommendation from several bodies such as the World Health Organization and others that feeding should be continued during diarrhoea, the practices of withholding food during the early stages of diarrhoea is still widespread. This contributes to deterioration in patient's nutritional state. The principle controversy in the nutritional therapy of acute gastroenteritis center on the relative risk of cow's milk feeds. The two things that need to be considered in determining the optimum approach to feeding the child with acute diarrhoea are the optimum timing for feeding children in relation to the onset of and recovery from symptoms and, secondly, the effects of specific food ingredients in the diet. Recent studies have demonstrated that the vast majority of young children with acute diarrhoea can be successfully managed with continued feeding of undiluted non-human milk. This literature also supports with the views of Brown et al, (1994), that the routine dilution of milk and routine use of lactose-free formula are not necessary especially when oral rehydration therapy and early feeding (in addition to milk) from the basic approach to the clinical management of diarrhoea in children. (15)
- Ramkrishna (2001), stated that Vitamin A and Zinc, nutrients essential for intestinal epithelial function, are lost during any diarrhoeal illness and depletion continues with more prolonged illness. This may intern contribute to impaired intestinal mucosal function and persistence of diarrhoea.
- Martinez-salgado et al. stated that locally available and culturally acceptable food is good for children with acute diarrhoea. Because children showed good acceptance of this diet, when caloric intake is enough, it will prevent weight loss. (12)

- Edet (1996), stated that the study on fluid intake and feeding practices among under five years old children during episodes of diarrhoea showed that fluid intake was low, only 54.0% and 43.3% of children received same or more food and fluid respectively as compared with before the diarrhoea and less than half of the children continued breast feeding. Target health education with emphasis on these findings, are recommended for improving fluid and food intake in the home management of diarrhoea.

2.6: Summary of the literature review

Diarrhoea disease is the most common and major single killer disease of under five years of age children in the developing countries. Diarrhoea is defined as three or more loose motions or watery stool in a day. Diarrhoeal diseases are one of the major causes of death and malnutrition in Nepal. Within first 5 years of child's life he/she experiences 4-6 episodes per year.

Various factors of diarrhoea such as age (under 2 years), season, low economic status, malnourished children, low breast fed babies, improper weaning, poor environmental sanitation, poor personal hygiene, lack of knowledge about the disposal of diarrhoea excreta, unsafe drinking water and un-proper hand washing after defecation etc. predispose to child to diarrhoea. The social factors also influence diarrhoeal prevalence rates. Higher prevalence rate (28%) were found to the children of youngest mother (15-19 years). The people who live in rural settings had higher risk of diarrhoea than urban. Male children had more than two folds odds for experiencing diarrhoea than female child.

So properly control of acute diarrhoea is the most effective way to prevent form persistent diarrhoea in developing countries, prevent malnutrition through giving proper and good food.

All children with diarrhoea need extra fluids to prevent or treat from dehydration. The emphasized fluids are home fluids or food based fluids (such as soup, rice water and yogurt drinks) or clean water and ORS fluid. Give fluid as much as the child will take or give fluids after each loose stool or vomit 50-100 ml for children < 2 years and 100-200 ml for children 2 years or over in addition to the normal fluid intake. Timing of fluid is very important to reduce duration of diarrhoea. The earlier finding showed the practice of fluid given to the child during diarrhoea was very low. NMIS report showed that 47% of the episodes not receiving any liquid and ORS preparation is also incorrect. The intake of either concentrated solution or diluted solution may give rise to life threatening hypernatremia and hyponatremia.

Breast fed children should be offered the breast milk more frequently and for a longer at each feed. For infants who are not breast fed, the usual milk feed should be given at least every three hours.

Thus maternal literacy, practice of giving fluid and food during episodes of diarrhoea and practices of seeking medical help for children with diarrhoea are key areas for intervention to reduce the associated mortality and long term of diarrhoea.

CHAPTER - III

RESEARCH METHODOLOGY

3.1 Research design of the Study:

The design of this study is a comparative research survey method. This study was done to find out the existing knowledge & practices of parents regarding home care of children under five years of age during diarrhoeal episodes. The investigator herself with the parents of under five years of age children collected data by using interview method and formal health education was given to the parents.

3.2 Population:

All of the parents whose under five children were registered in medical OPD for the treatment of diarrhoea in Kanti Children Hospital.

3.3 Sample size:

Total fifty (50) parents were taken (25 urban & 25 rural) as the sample for the study.

3.4 Sampling method:

In this study quota sampling technique was used to collect the data.

3.5 Data collecting setting:

Medical OPD of the Kanti Children Hospital.

3.6 Inclusion criteria:

Parents of under five years (6 months to 5 years) children who came for the treatment of diarrhoea of his/her child.

3.7 Exclusion criteria:

- Who are not willing to participate in the study.
- Parents who couldnot speak Nepali.

3.8 Instrumentation:

Combination of closed and semi structured interview schedule was developed considering the study variables. There were two sections.

- a) Demographic data
- b) Data related to knowledge and practice of parents regarding care during diarrhoea.

3.9 Validity of the instrument:

For the validity of the instrument, content validity is the major focus for this study. This was concerned with whether the instrument adequately covered the content and measured what is supposed to measure. The investigator developed the questionnaire by consulting related and reviewing literature. To check the content validity of instrument the questionnaire was shown to colleague, research advisor, and other teachers.

3.10 Pretest:

Pretest was done among the parents of 6 months to 5 years children in Kanti Children Hospital and necessary changes and modifications were made in instrument to add to its clarity, adequacy, sequential and those parents were not included in the actual research study.

3.11 Data collection procedure:

Written permission letter was sent to the Kanti Children Hospital from the Campus. Then the investigator was obtained verbal permission from the Nursing director and associated ward in-charge for the data collection.

3.12 Statistical test:

After data collection, the collected data was analyzed and tested by percentage and frequency. Then it was analyzed and interpreted by using different tables, graphs and charts.

3.13 Ethical consideration

Before starting data collection, verbal permission was taken from the parents who were participated. No one was forced to take part in the research study unless they agreed to be interviewed. The collected data concerning individual was kept confidential and results were only reported in-group form.

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

4.1: Data Analysis Interpretation and presentation in tables and charts.

This chapter includes the socio-demographic, economic background, knowledge and practice regarding care of children under five during diarrhoea of Urban and rural parents presented in this chapter.

PART-I

A. Demographic data related to child.

1. Percentage distribution of respondent's children according to their gender and age group.

Age of Children	Urban				Rural				Percentage
	Male	Percentage	Female		Percentage	Male	Percentage	Female	
6 month-2 yrs	10	40%	5		20%	15	60%	5	20%
3 years-4 years	5	20%	3		12%	2	8%	1	4%
4 years – 5 years	2	8%	-		-	2	8%	-	-

Table No. 1

The Table No. 1 shows that out of 25 urban children with diarrhoea, 17 (68%) were male children. Among them 40% were between the ages of 6 months to 2 years, 20% were between the age of 3 to 4 years and 8% were between the ages of 4 To 5 years.

The remaining 8 (32%) were female children. Among them 20% were between the age of 6 months to 2 years and 12% were between the age of 3 to 4 years.

Similarly, in rural 19(76%) were male and 6 (24%) were female children.

These findings shows that majority of Children were male and the between age group of 6 month to 2 years. This might be due to parents more sensitive to male child rather than female and low immunity of children under 2 years.

Table 2. Percentage distribution of Children according to onset of diarrhoea.

One set of diarrhoea	Urban		Rural	
	Number	Percentage	Number	Percentage
1-3 days	13	52%	14	56%
4-6 days	4	16%	4	16%
Above 7 days	8	32%	7	28%
Total	N=25	100%	25	100%

Above table No. 2 shows that onset of diarrhoea among 25 children in urban areas, 1-3 days were 52%, 4-6 days were 16% and above 7 days were 32%.

Similarly, in 25 rural children, 1-3 days were 56%, 4-6 days were 16% and above 7 days were 28%.

This finding shows that not more different of onset of diarrhoea in Urban and Rural children who were brought in hospital.

Table 3. Percentage distribution of respondent's children according to degree of dehydration.

Degree *	Urban		Rural	
	Number	Percentage	Number	Percentage
Mild	16	64%	20	80%
Moderate	9	36%	5	20%
Total	N=25	100%	N=25	100%

* Degree of dehydration was differentiated according to Dr.

Above table No. 3 shows that higher percentage 64% mild dehydration was found in Urban Children respectively 80% mild dehydration was found in rural areas. Low percentage 36% moderate dehydration was found in urban children respectively 20%

moderate dehydration was found in rural children. No any children were suffered from severe dehydration both in Urban and Rural.

Table 4. Percentage distribution of Children according to history of previous hospital visit for diarrhoeal management.

Frequency of visit	Urban		Rural	
	Number	Percentage	Number	Percentage
First time	13	52%	15	60%
More than 1 time	12	48%	10	40%
Total	N=25	100%	N=25	100%

Above table shows that out of 25 urban children, 52% were visited to hospital first time, the remaining 48% were visited to hospital more than one time.

Similarly out of 25 rural children, 60% were visited to hospital first time, others 40% were visited more than one time.

(B) Demographic data related to parents.

Table 5. Percentage distribution of respondents according to their gender and age group.

Age groups	Urban				Rural			
	Number of mother	Percentage	Number of father	Percentage	Number of mother.	Percentage	Number of father.	Percentage
15-19 years	1	4%	-	-	-	-	-	-
20-24 years	14	56%	-	-	12	48%	1	4%
25-29 years	7	28%	2	8%	6	24%	1	4%
30-39 years	-	-	1	4%	2	8%	-	-
Above 40	-	-	-	-	2	8%	1	4%
Total	22	88%	3	12%	22	88%	3	12%

This table shows that majority of respondents 88% mother were both in Urban and rural. Similarly, low percentage (12%) father were both in Urban and rural.

Out of 25 parents, (56%) were between the age of 20 to 24 years and lower percentage (4%) were between the age of 30-39 years in Urban areas.

Similarly, 25 parents in rural, (48%) were between the age of 20 to 24 years and low percentage (4%) were above the age of 40 years.

These findings shows that majority age group of mother were between 20-24 years, this might be respectively due to first care provider to the child and early marriage.

Table 6. Percentage distribution of respondents according to their educational level.

Educational Status	Urban		Rural	
	Number	Percentage	Number	Percentage
▪ Illiterate	7	28%	5	20%
▪ 5 Class	4	16%	2	8%
▪ 6-10 Class	7	28%	13	52%
▪ Certificate	6	24%	3	12%
▪ Diploma or more over	1	4%	2	8%
Total	N=25	100%	25	100%

Findings of the above table shows that even though in rural parents, low percentage (20%) were illiterate rather than in Urban (28%). Next findings show that high school level education was high also in rural areas. But certificate level and diploma level education was low in rural parents rather than Urban.

Table 7. Percentage distribution of respondents according to their occupation

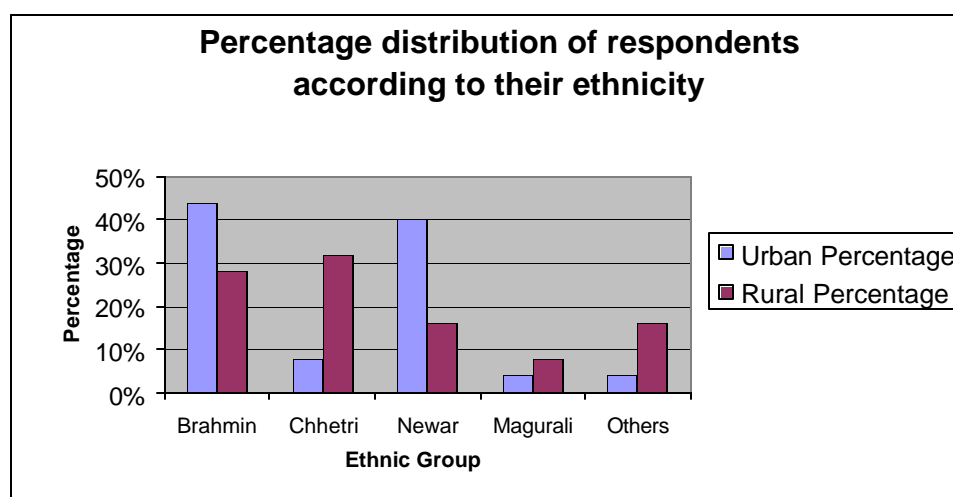
Occupations	Urban		Rural	
	Number	Percentage	Number	Percentage
House Wife	19	76%	21	84%
Service	4	16%	2	8%
Business	2	8%	1	4%
Agriculture	-	-	1	4%
Others	-	-	-	-
Total	N=25	100%	25	100%

Above table shows that out of 25 parents in Urban, 76% were housewife, 16% were service holder and 8% were engaged in business.

Similarly, out of 25 parents in rural, 84% were housewife, 8% were service holder, equal percentage (4% and 4%) were engaged respectively in business and Agriculture.

These findings show that majority of parents were housewives. It might be due to majority of respondents were mother.

Figure 1. Percentage distribution of respondents according to their ethnicity.



Above figure shows that out of 25 respondents in Urban, majority (44%) were from Brahman family, 40% were from Newar, 8% were from Chhetri and equal (4% and 4%) were respectively from Maguruli and others (Tamang, Tharu).

Similarly, out of 25 rural respondents, majority (32%) were Chhetri, 28% were Brahmin, and low percentage (8%) were from maguruli but equal percentage (16% and 16%) were from respectively Newar and others (Lama, B.K., Tharu).

Table 8 . Percentage distribution of respondents according to their religion.

Religion	Urban		Rural	
	Number	Percentage	Number	Percentage
Hindu	24	96%	18	72%
Buddha	1	4%	6	24%
Christian	-	-	1	4%
Muslim	-	-	-	-
Total	N=25	100%	25	100%

Above table shows that out of 25 respondents, the higher percentage (96%) were from Hindu and the lower percentage (4%) were from Buddha in urban areas.

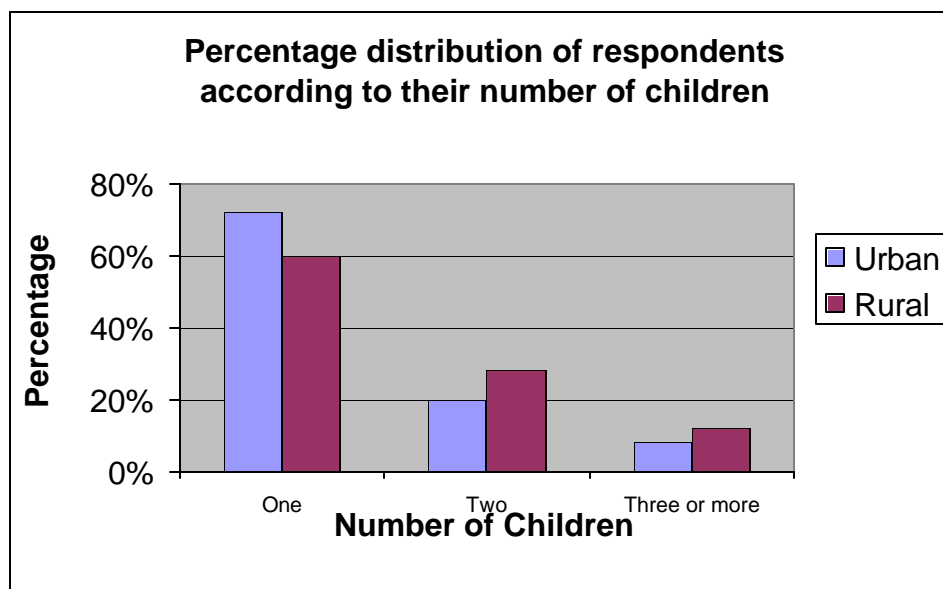
Similarly, out of 25 in rural respondents, (72%) were from Hindu, (24%) were from Buddha, and (4%) wherefrom Christian.

Table 9 . Percentage distribution of respondents according to their family structure.

Types of Family	Urban		Rural	
	Number	Percentage	Number	Percentage
Nuclear	15	60%	12	48%
Joint	10	40%	13	52%

The family structure of Urban and rural areas shows to the table No.10. The Majority of Urban respondents were from nuclear family (60%) whereas (40%) were from joint family. Similarly, majority of the respondents in rural areas, (52%) were from joint family and (48%) were from nuclear family.

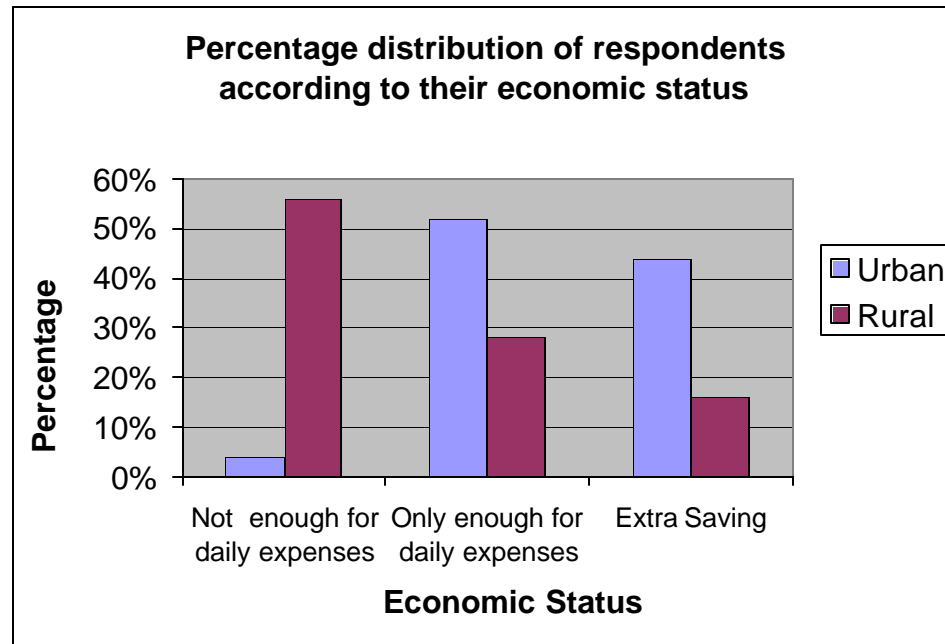
Figure 2 . Percentage distribution of respondents according to their number of Children.



Above figure shows that majority parents of Urban had 1 child (72%), 20% of respondents had two children and 8% had 3 or more children.

Similarly, parents of rural children, 60% had one child, 28% parents had two children and 12% respondents had three or more children.

Figure 3 . Percentage distribution of respondents according to their economic status.



Adequacy of income has direct impacts on health of people. According to the above figure, out of 25 Urban respondents, (52%) were had enough to eat yearly, (44%) had extra saving and (4%) had not enough to eat yearly.

Similarly, out of 25 respondents of rural areas, (56%) had not enough to eat in a year, 28% had satisfactory economic condition and 16% had extra saving capacity.

PART II

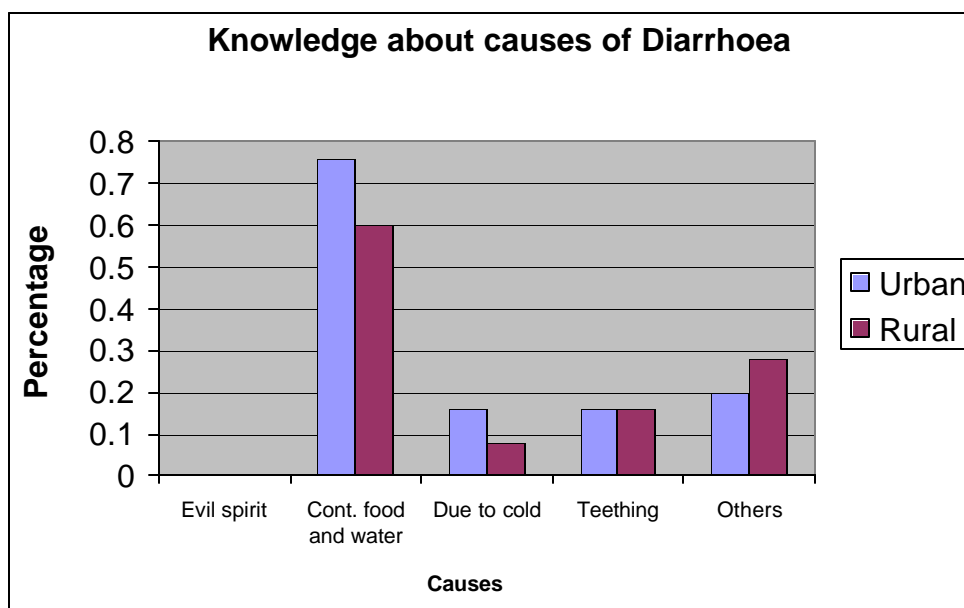
A. KNOWLEDGE ITEMS

Table 10. Percentage distribution of respondents according to knowledge about meaning of diarrhoea.

Options	Urban		Rural	
	Number	Percentage	Number	Percentage
3 or > times watery stool in a day	21	84%	20	80%
2 times semisolid stool	-	-	-	-
1 times watery stool	4	16%	5	20%
Total	N=25	100%	25	100%

Above table shows that majority of respondents both in Urban and rural had known about meaning of diarrhoea. Only low percentage of respondents did not know about meaning of diarrhoea both in Urban and rural areas.

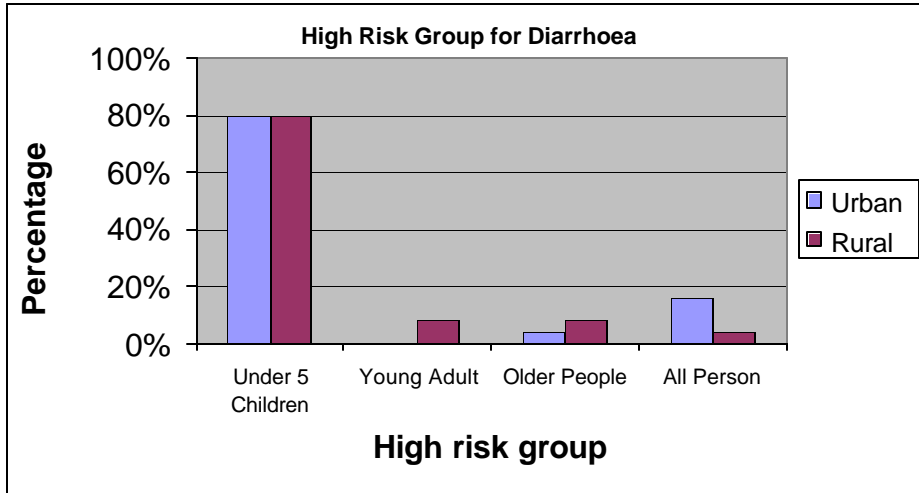
Figure 4. Percentage distribution of respondents according to knowledge about causes of diarrhoea.



*Respondents have given more than one response.

Above figure shows that majority of respondents in both areas have knowledge about causes of diarrhoea. Majority of respondents, (76%) were known about causes of diarrhoea in urban and (60%) of rural parents were also known about causes of diarrhoea.

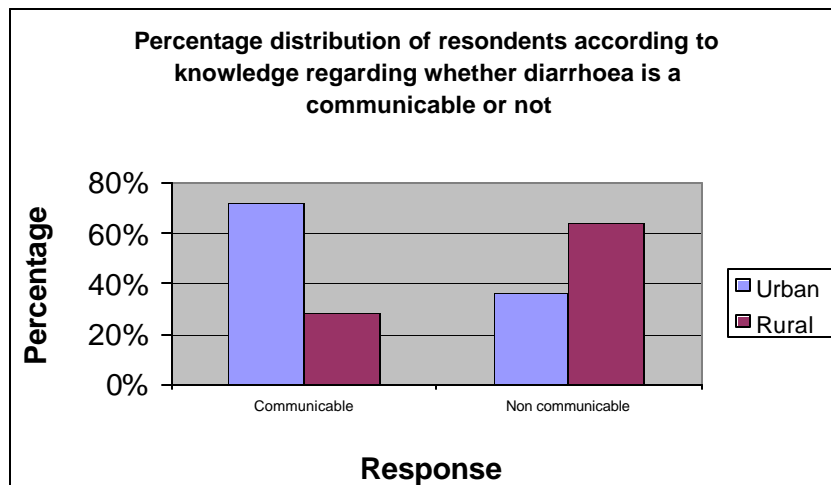
Figure 5. Percentage distribution of respondents according to knowledge regarding high-risk group for diarrhoea.



Above figure shows that out of 25 respondents in urban areas, (80%) of respondents were stated that under 5 children are risk for diarrshoea, (4%) were stated for older people and (16%) were stated for all person.

Similarly, 25 respondents of rural areas (80%) were stated that under 5 children are risk for diarrhoea, (8%) were stated for youngadult, another (8%)were stated for older people and the remaining (4%) were stated for all person are risk for diarrhoea.

Figure 6 . Percentage distribution of respondents according to knowledge regarding whether diarrhoea is a communicable or not.



Above figure shows that (72%) of respondents in urban areas believed that diarrhoea is communicable but (64%) of respondents in rural areas believed that diarrhoea is not communicable. Similarly, (28%) of respondents in urban areas believed that diarrhoea is not communicable but (36%) of rural respondents believed that diarrhoea is communicable disease.

Table 11 . Percentage distribution of respondents according to knowledge regarding severity of diarrhoea.

Response	Urban		Rural	
	Number	Percentage	Number	Percentage
Simple	2	8%	8	32%
Dangerous	11	44%	13	52%
Both	12	48%	4	16%
Total	25	100%	25	100%

Above table shows that among 25 respondents of urban areas, Majority (48%) respondents were stated that diarrhoea is both simple and dangerous, (44%) of respondents were stated that diarrhoea is dangerous and (8%) of respondents were stated the diarrhoea is simple disease.

Similarly, among 25 respondents of rural areas, majority of respondents (52%) stated that diarrhoea is dangerous, (32%) were answered simple, and (16%) were answered the diarrhoea is both simple and dangerous disease.

Table 12. Percentage distribution of respondents according to knowledge regarding diarrhoea is preventable or not.

Responses	Urban		Rural	
	Number	Percentage	Number	Percentage
Yes	19	76%	19	76%
No	6	24%	6	24%
If Yes how *	N=19		N=19	
By proper sanitation	18	94.74%	16	84.21%
By proper hygiene	7	36.84%	8	42.11%
By using boiled water	7	36.84%	9	47.37%

* = Respondents have given more than one response.

Above table shows that respondents were equal percentage both in Urban and rural respectively, i.e. (76%) of respondents were answered that diarrhoea is preventable but (24%) of respondents were answered that diarrhoea is not preventable. The question asked among 19 urban respondents, how to prevent the diarrhoea? Among 19 Urban respondents, 18 respondents were answered by proper sanitation, 7 respondents were

answered by proper hygiene and other 7 respondents were answered that diarrhoea can prevent by using boiled water regularly.

Similarly, the same question asked to 19 rural respondents, How to prevent diarrhoea? Among 19 answers from rural respondents, 16 respondents were answered by proper sanitation, 8 respondents were answered by proper hygiene and other 9 respondents were answered that the diarrhoea can prevent by using boiled water.

Table 13. Percentage distribution of respondents according to knowledge regarding whether food is better or not during diarrhoea.

Responses	Urban		Rural	
	Number	Percentage	Number	Percentage
Yes	25	100%	25	100%
No	-	-	-	-
Total	25	100%	25	100%

Above table shows that cent percent Urban and rural respondents have better knowledge regarding food during diarrhoea.

Table 14. Percentage distribution of respondents according to knowledge about types of food to be given during diarrhoea.

Types	Urban		Rural	
	Number	Percentage	Number	Percentage
Liquid	25	100%	24	96%
Solid	-	-	-	-
As Usual	-	-	1	4%
Total	25	100%	25	100%

Above table shows that cent percent of urban parents stated that liquid food is better during diarrhoea.

Similarly, (96%) of rural parents stated that liquid food and (4%)of rural respondents stated that as usual food is better to provide during diarrhoea.So,It is indicates the more awareness of respondents about food during diarrhoea.

Table 15. Percentage distribution of respondents according to knowledge regarding dangerous complication of diarrhoea.

Responses	Urban		Rural	
	Number	Percentage	Number	Percentage
Yes	10	40%	8	32%
No	15 N=10	60%	17 N=8	68%
If yes, what are they?	4	40%	1	12.5%
Weakness	1	10%	1	12.5%
Malnutrition	5	50%	6	75%
Death				

Above table shows that among 25 urban respondents, (60%) of respondents did not know about dangerous complication of diarrhoea, but (40%) had some knowledge. Among them, 4 respondents stated weakness, 1 respondent stated malnutrition and other 5 respondents stated that death is a complication of diarrhoea.

Similarly, among 25 rural respondents, (68%) respondents did not know about dangerous complication of diarrhoea but, only (32%) had some knowledge.

This result indicates that majority of respondents both in Urban and rural areas had not knowledge about dangerous complication of diarrhoea.

Table 16. Percentage distribution of respondents according to knowledge, When should a child taken to hospital during diarrhoea.

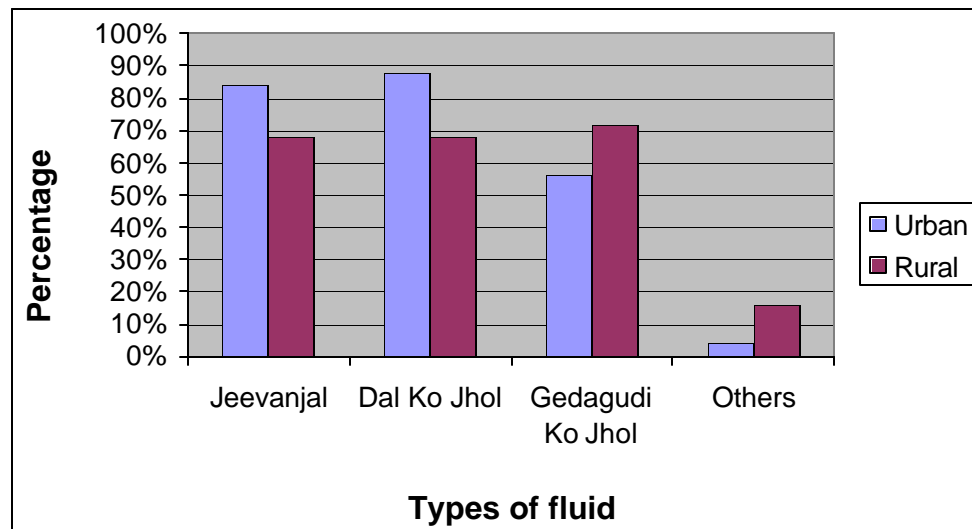
Responses (conditions) *	Urban N=25		Rural N=25	
	Number	Percentage	Number	Percentage
Continuous diarrhoea	24	96%	19	76%
Continuous vomiting	12	48%	13	52%
Blood in stool	8	32%	5	20%
Child's can't shock	3	12%	4	16%
Breast milk and can't take liquid orally				

* Respondents have given more than one responses.

Above table shows that Urban and rural both respondents had more knowledge about serious condition of child during diarrhoea. In above figure (96%)of Urban people emphasis on continuous diarrhoea, (48%) of respondents gave more emphasis on continuous vomiting,(32%) gave emphasis on blood in stool and rest (12%) gave emphasis on, when child's can't shock breast milk or can't take fluid orally.

Similarly, among 25 rural respondents, (76%) were given more emphasis on continuous diarrhoea, (52%) were on continuous vomiting, (20%) were Blood in stool and rest (16%) were gave emphasis on, when child's can't shock breast milk or liquid fluid orally.

Figure 7. Percentage distribution of respondents according to knowledge regarding types of fluid that can be given to the child during diarrhoea.



* Respondents have given more than one responses.

Above figure shows that majority of Urban and rural respondents have knowledge about, what types of fluid to be given during diarrhoea. In Urban, they were (88%), (84%), (56%) and (4%) respectively, Dal Ko Jhol, Jeevanjal, Gedagudi Ko Jhol and others like fruits juice, soup of chau chau, Anar etc.

Similarly, in rural areas of respondents were equal percentage for Jeevanjal and Dal Ko Jhol i.e. (68%) and other majority respondents were on Gedagudi Ko Jhol i.e. (72%) and rest (16%) were for Banana, vegetable's soup, milk etc.

Table 17. Percentage distribution of respondents according to knowledge regarding jeevanjal.

About Jeevanjal	Urban		Rural	
	Number	Percentage	Number	Percentage
Knows about jeevanjal:				
• Yes	23	92%	24	96%
• No	2	8%	1	4%
Knowledge about types of water to be used in jeevanjal:	No =23		No=24	
• Boiled and cooled	21	91.31%	19	79.17%
• Warm	2	8.69%	5	20.83%
• Tape	-	-	-	-
Knowledge about amount of water to be added to a jeevanjal packet:	N=23		N=24	
• 1 glass	-	-	-	-
• 1/2 glass	-	-	-	-
• 6 full glass of water or 1 liter	23	100%	23	95.83%
• Others	-	-	1	4.17%
Knowledge about how long (save period) can be used after in preparation of jeevanjal:	N=23	100%	N=24	100%
• Till finishing	1	4.35%	2	8.33%
• 6 hrs	-	-	2	8.33%
• 24 hrs	21	91.30%	18	75%
• Others	1	4.35%	2	8.33%

Above table shows that majority of Urban and rural respondents have better knowledge about jeevanjal i.e. types of water to be needed for preparing jeevanjal, amount of water for jeevanjal and period can be used jeevanjal. No significant different between Urban and rural respondents knowledge.

B. Practice Items

Table 18. Percentage distribution of respondents according to knowledge regarding whether they give water to child during diarrhoea or not.

Responses	Urban		Rural	
	Number	Percentage	Number	Percentage
Yes	25	100%	23	92%
No	-	-	2	8%
Total	N=25	100%	N=25	100%

Above table shows that cent percent respondents of urban areas had given water during diarrhoea. Similarly, most of respondents i.e. (92%) of rural areas had given water during diarrhoea only (8%) respondents of rural areas had not given water during diarrhoea due to vomiting and child's refused.

Table 19. Percentage distribution of respondents according to types of water given during diarrhoea.

Types of water*	Urban		Rural	
	Number	Percentage	Number	Percentage
Plain water	19	76%	14	56%
Jeevanjal	20	80%	7	28%
Glucose water	2	8%	4	16%
Total	N=25		N=25	

* = Respondents have given more than one response.

Above table shows that most of Urban and rural parents have better knowledge about types of water. Among in Urban parents, (80%) were jeevanjal, (76%) were plain water and other (8%) were Glucose water.

Similarly, in rural parents, (56%) had given plain water, (28%) had given Jeevanjal and other (16%) had given Glucose water.

So, this finding shows that majority of urban parents were used jeevanjal rather than rural parents.

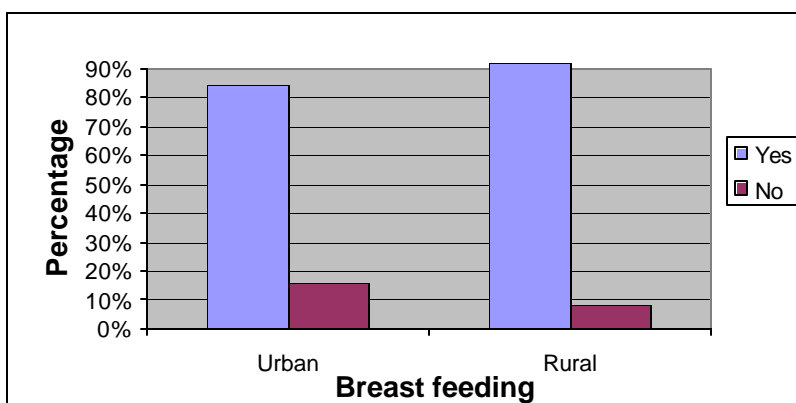
Table 20. Percentage distribution of respondents according to frequency of water (jeevanjal) given in a day.

Time Frequency*	Urban		Rural	
	Number	Percentage	Number	Percentage
2-4 times	-	-	1	4.16%
4-6 times	4	16%	2	8.33%
When the child demanded	13	52%	9	37.5%
After each episodes of diarrhoea.	15	60%	12	50%
Total	N=25		N=24	

*Respondents have given more than one response

Above table shows that (60%) of Urban respondents and (50%) of rural respondents had given water correctly to the child during diarrhoea.

Figure 8. Percentage distribution of respondents according to breast-feeding status of their children.



Above figure shows that majority of Urban and rural respondents had positive practice on breast-feeding. (16%) urban respondents and (8%) rural respondents respectively had not fed breast milk to their children because of age above 2 years.

Table 21. Percentage distribution of respondents according to their continuation of breast-feeding to their children during diarrhoea.

Breast feeding	Urban		Rural	
	Number	Percentage	Number	Percentage
Yes	21	100%	23	100%
No	-	-	-	-
Total	N=21	100%	N=23	100%

Above table shows that cent percent of urban and rural respondents had fed continuous breast milk to their children during diarrhoea.

Table 22. Percentage distribution of respondents according to frequency of breast-feeding to their children during diarrhoea.

Pattern of breast feeding	Urban		Rural	
	Number	Percentage	Number	Percentage
As usual	2	9.52%	2	8.69%
Less than usual	5	23.31%	4	17.39%
More than usual	14	66.67%	17	73.91%
Total	N=21	100%	N=23	100%

Above table shows that majority of Urban and rural parents had good practice about breast-feeding pattern during diarrhoea. Among the total respondents of Urban and Rural, (66.67%) and (73.91%) respectively had breast-fed more frequently and correctly.

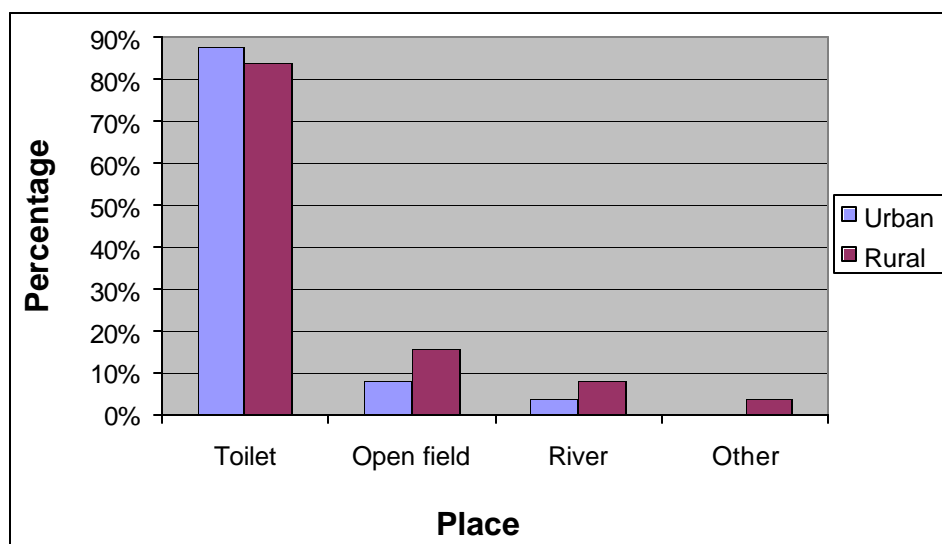
Table 23. Percentage distribution of respondents according to their practice of giving additional food to children during diarrhoea.

Feeding Practice	Urban		Rural	
	Number	Percentage	Number	Percentage
Additional food:				
Yes	23	92%	19	76%
No	2	8%	6	24%
	No-25	100%	No-25	100%
Types: *	N=23		N=19	
Jaulo	23	91.31%	15	78.94%
Dal Ko Jhol	15	65.23%	7	36.84%
Gedagudi Ko Jhol	11	47.83%	4	21.05%
Others	-	-	6	31.57%
Frequency:	N=23		N=19	
Usual	4	17.39%	3	15.78%
Less than usual	8	34.78%	5	26.31%
More than usual	11	47.83%	5	26.31%
As per child's demand	-	-	6	31.57%
Reason for not giving food	No-23	100%	N-19	100%
Indigestion	-	-	-	-
Due to vomiting	-	-	4	16%
Child's refuse	2	8%	2	8%

Above table shows that most of respondents had given additional food both in Urban and rural. But respondents of urban areas have better practice of food rather than rural respondents. Out of 25 respondents, 23 had given additional food to their children during diarrhoea, among them cent percent of respondents had given Jaulo, (65.23%) had given Dal Ko Jhol and (47.83%) of respondents had given Gedagudi Ko Jhol. Among 23 respondents of Urban areas had given food more than usual, (34.78%) had given food less than usual and (17.39%) of respondents had given food as usual only (8%) of Urban respondents had not given food due to child's refuse. Similarly, out of 25 respondents of rural areas, (76%) had given food to their children during diarrhoea. Among them (78.94%) had given jaulo, (36.84%) had given Dal Ko Jhol, (21.05%) had given Gedagudi Ko Jhol and (31.57%) of respondents had given others food like milk, ma'd and banana etc. Among (76%) of rural respondents, (31.57%) had given food as per child's demand, (26.31%) had given food more than usual, next (26.3%) had given food less than usual and (15.78%) had given food as usual. Among other (24%) of

respondents, (16%) had not given food due to vomiting and (8%) had not given food due to refusing their children.

Figure 9. Percentage distribution of respondents according to place for disposing their child's diarrhoeal excreta.



Above figure shows that majority of Urban and rural respondents had positive practice about disposing child's diarrhoeal excreta. Among 25 respondents (88%) of Urban parents had disposed in toilet, (8%) had disposed in open field and (4%) of respondents had disposed in river.

Similarly, out of 25 respondents of rural areas, (84%) of respondents had disposed in toilet, (8%) had disposed in River, (4%) had disposed on open field and another (4%) had disposed in others (washed the stool cloths in tape) areas.

Table 24. Percentage distribution of respondents according to practice about hand washing after disposing of child's diarrhoeal excreta.

Hand Washing	Urban		Rural	
	Number	Percentage	Number	Percentage
Yes	25	100%	25	100%
No	-		-	
Types of material used in hand washing	No-25		No-25	
• With soap and water	25	100%	23	92%
• With ash and water	-	-	2	8%
• With mud and water	-	-	-	-
Total	25	100%	25	100%

Above table shows that cent percent of Urban and rural respondents had better practice about hand washing. Among them cent percentage of Urban respondents were used with soap and water for hand washing. In Rural, (92%) had used with soap and water and (8%) had used with Ash and water for hand washing.

Table 25. Percentage distribution of respondents practice regarding cleaning the child's buttock after each defecation.

Responses	Urban		Rural	
	Number	Percentage	Number	Percentage
Cleaning?				
• Yes	25	100%	25	100%
• No	-	-	-	-
Types of material used in cleaning the buttock:				
• Water	24	96%	22	88%
• Pieces of old cloths	1	4%	3	12%
Total	No=25	100%	No=25	100%

Above table shows that cent percent respondents were cleaning their child's buttock after each defecation both in Urban and Rural.

Among 25 respondents of Urban, (96%) of respondents had used water for cleaning and only (4%) of respondents had used pieces of old cloths for cleaning the child's buttock. Similarly, Among 25 respondents of rural, (88%) had used water and (12%) of respondents had used pieces of old cloths for cleaning their child's buttock.

Table 26. Percentage distribution of respondents according to their reasons for bringing their child to the hospital during diarrhoea.

Reasons*	Urban		Rural	
	Number	Percentage	Number	Percentage
Due to uncontrolled diarrhoea.	24	96%	23	92%
Vomiting	4	16%	5	20%
Blood seen in stool	2	8%	1	4%
Other	2	8%	1	4%
Total	No=25		No=25	

*Respondents have given more than one reason.

Above table shows that majority of respondents were awarded for bringing child to hospital both in Urban and rural areas.

Among 25 respondents in urban (96%) of children were bringing to hospital due to uncontrolled diarrhea, (16%) were due to continuous vomiting, (8%) were due to blood

seen in stool and remaining (8%) were due to other (abdomen pain child's can't shock) reasons.

Similarly, Out of 25 respondents in rural, (92%) of children were bringing to hospital due to uncontrolled diarrhea, (20%) were due to continuous vomiting, (4%) were due to blood seen in stool and remaining (4%) were due to other (abdomen pain) reasons.

Table 27. Percentage distribution of respondents according to whether child had checked up by others or not before came to hospital.

Checked up by other or not	Urban		Rural	
	Number.	Percentage.	Number.	Percentage.
• Yes	14	56%	16	64%
• No	11	44%	9	36%
If yes, by whom?	N=14		N=16	
-Health personnel	14	100%	14	87.5%
-Dhami Jhakri	-	-	2	12.5%

Above table shows that the total respondents from urban areas were 25 and 25 were also from rural areas. Out of these 25 respondents, (56%) from Urban children and (64%) from rural children were pre checked before came to hospital and remaining (44%) children from urban as well as (36%) children from rural areas were not checked before came to hospital.

Similarly, among these pre checked total children both from Urban and rural areas, cent percent children from Urban were pre checked by health personnel and no more recorded for Dhami / Jhakri. But (12.5%) children from rural areas were pre checked by Dhami / Jhakri even though (87.5%) children were also pre checked by health personnel.

CHAPTER V:

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Main Findings of the study

1. Diarrhoea was predominantly seen in male children both in urban and rural areas. In urban 68% were male children and in rural 76% were male children.
2. Diarrhoea was seen in age between 6 months to 2 years. In rural 60% of children were age between 6 months to 2 years and in urban 40% of children were age between 6 months to 2 years.
3. Most of children were suffered from mild dehydration. 64% percentage in urban and 80% in rural, were suffered from mild dehydration.
4. Majority of children were visited to hospital first time. In urban children 52% were visited to hospital first time and in rural 60% of children were visited to hospital first time.
5. Majority of the respondents (88% & 88%) in both areas were mother and majority of mother were age group between 20-24 yrs.
6. Majority of respondents were literate both in urban & rural areas. 80% were in rural & 72% were in urban.
7. Majority of the respondents in both areas were housewives, 76% in urban and 84% in rural.
8. Majority of the respondents (44%) in urban areas were from Brahman ethnicity and majority of the respondents (32%) in rural areas were chhetri.
9. Majority of respondents were Hindu both in urban and rural areas. 96% percentage in urban and 72% in rural.
10. Majority (60%) of the respondents in urban areas lived in a nuclear family where as most of respondents of rural areas (52%) lived in joint family.
11. Majority of respondents both in urban and rural areas have one child 72% in urban and 60% in rural.
12. Majority of respondents in urban parents had satisfactory economic status (52%). But 56% of rural respondents had poor economic condition.
13. Most of respondents were known the meaning of diarrhoea both in urban and rural. In urban 84% and in rural 80% had known.
14. Majority of respondents (76%) in urban and 60% of rural respondents knew the causes of diarrhoea.
15. Majority of respondent 80% in urban areas and also 80% of rural respondents stated that under 5 children are most risk for diarrhoea.
16. Majority of respondents (72%) in urban areas stated that diarrhoea is communicable where as 64% of respondents in rural areas stated that diarrhoea is not communicable.
17. Most of respondent of (48%) urban areas stated that diarrhoea is both (Simple + Dangerous) disease but most of respondent (52%) in rural areas stated that diarrhoea is dangerous disease.

18. Equal percentage (76%&76%) of respondents both in urban and rural stated that diarrhoea is preventable by proper sanitation, proper hygiene and by using boiled water.
19. Cent percent of respondents were accepted that food is better during diarrhoea both in urban and rural areas.
20. Cent percent of respondents in urban areas and most of (96%) respondents in rural areas stated that liquid food is better during diarrhoea.
21. Most of respondents (60%) in urban areas and 68% of respondents in rural areas had not knowledge regarding dangerous complication of diarrhoea.
22. Most of respondent (96%) in urban and 76% of respondent in rural stated that during uncontrolled diarrhoea, child must be taken to hospital.
23. Majority of respondents (88%) in urban areas stated that Dal Ko Jhol is better during diarrhoea and (72%) of respondents in rural areas stated that gedagudi Ko Jhol is better as liquid food during dearrhoea.
24. Majority respondents of rural (96%) and most of respondents (92%) in urban had knowledge regarding jeevanjal.
25. Cent percent of respondents in urban areas and 92% of respondents in rural areas were giving additional water during diarrhoea.
26. Most of respondents (80%) in urban areas had given jeevanjal but 56% of respondents in rural areas had given plain water during diarrhoea.
27. Majority of urban respondents 60% and 50% of rural respondents were giving fluid in correctly.
28. Majority of rural (92%) respondents and 84% of urban respondents were breast-feeding to their children and cent percent respondent were continuous breast-feeding during diarrhoea. Among them 66.67% of urban parents and 73.91% of rural parents had breast-fed more frequently.
29. Majority of respondents (92%) in urban areas and most of respondents (76%) in rural areas were giving food during diarrhoea. Among them cent percent of respondent in urban and 78.94% of respondents in rural areas were giving jaulo to their children during diarrhoea.
30. Minority of respondents (8%) in Urban and 24% of respondents in rural areas were not giving food because of vomiting and Childs refusing.
31. Majority of respondents (88%) in urban and 84% of respondents in rural were disposing his/her child's diarrhoeal excreta in toilet.
32. Cent percent of respondents were hand washing after disposing child's diarrhoeal excreta both in urban and rural areas. And cent percent respondent of urban areas and 92% of respondents of rural areas were used soap and water for handwashing.
33. Centpercent of respondents were cleaning the child's buttock after each defecation both in urban and rural areas. Among them 96% of urban respondents and 88% of rural respondents were cleaning the child's buttock with water.
34. Most of children (96%) of urban areas and 92% of children in rural areas were visited to hospital because of uncontrolled diarrhoea.
35. Most of children (64%) of rural areas and 56% of urban children were checked to others before came to the hospital. Among them cent percent of urban children and 87.5% of rural children were checked by the health personnel.

5.2 Conclusion

This small-scale comparative study of knowledge and practice regarding "home care of children during diarrhoea in urban and rural parents attending in Kanti Children Hospital" was done in the month of jetha, 2000.

On the basis of analysis and interpretation of the data, following conclusion has been drawn: -

- 1) Majority of urban and rural parent have adequate knowledge about meaning of diarrhoea, its causes, risk group, types and severity of diarrhoeal disease, types of food and fluid to be needed, jeevanjal preparation etc. But majority of Urban and rural parents have not knowledge regarding dangerous sign of diarrhoea.
- 2) The majority of Urban and rural parents have positive practice on additional water during diarrhoea, types of water, types and quality of food and fluids, breast feeding patterns and its continuation, disposing child's diarrhoeal excreta, hand washing, cleaning the child's buttock after each defecation etc.
- 3) The results of this study indicate that knowledge and practice of rural parents not low in relation to urban parents. It might have been due to education status, facilities of communication, transportation and residential area because most of all rural parents were from Kathmandu Valley than out of Valley.

5.3 Comparison of findings with literature reviewed.

According to the literature reviewed regarding knowledge and practice of parents during diarrhoea, the results of the research demonstrated as follows.

1. The findings of this study shows that 60% of urban children and 80% of rural children with diarrhea rise under the age group between 6 months to 2 years, then gradually reduced on number of diarrhoeal children after 2years. It is supported by Lohani(2000) and Adhikari (1997) as they stated that diarrhea is more common in children under age of 2 years.
2. Mock at el. (1993), who stated that male children had a more than two fold odds of experiencing recent diarrhea than did female children among those grater than 1 years of age. Similarly in this study 40% of urban male children and 60% male children in rural were more suffered from diarrhea, this is higher than female children respectively 20% in urban and 20%also in rural. Thus this literature supports this research study.
3. Al-mazrou and et al (1995) stated that the factors associated with higher prevalence rate were the children of youngest mother. Similarly in this study shows that majority of mother were aged between 20-24 yrs. Thus this literature supports this research study.
4. Al mazrou et al 1995 also stated that the prevalence rate of diarrhea was higher (15%), in those who lived in rural setting than in those who lived in urban setting. Similarly during this study most of the respondents were from rural areas and researcher had felt difficulties to find out urban parents. After 2 weeks of data

- collection of rural respondents then she could find urban cases hardly. Thus this literature supports this research study.
5. Oni (1996), stated that children of mother with secondary education had significantly higher risk of diarrhea compared with children with illiterate. Similarly in this study shows that majority of mother (28%) in urban and 52% of mother in rural areas were secondary level education. Respectively 28% of urban mother and 20% of rural mother were illiterate. Thus this literature supports this research study.
 6. Lohani (2000), who stated that diarrhea is more common in low socioeconomic group. Similarly in this study shows that most of respondents belonged to lower class economic condition in rural areas but in urban respondents were belonged to middle class than lower or higher class. So this literature only supported to rural respondents.
 7. National diarrhoeal disease controlled programme (1996) and Edet E E (1996), stated that 47% of the episodes not receiving any liquid and fluid intake also was low. But findings of this study shows that cent percent respondents in urban and 92% of respondents in rural areas were giving fluid during diarrhea. Only 8% of rural respondents were not given water during diarrhea due to vomiting and child's refusing. Thus this literature not supports this research study.
 8. Al et al (2000), and national diarrhoeal disease control programme HMG Nepal (1996), stated that use rate of oral rehydration therapy for management of diarrhea was inadequate and only (35%) were found to have used ORS. Similarly Yadav and Singh (1997) and Adhikari (1997) stated that Rice water salt solution is more effective in managing acute watery diarrhea. But findings of the present study, shows that majority of respondents (80%) in urban areas had given jeevanjal to their children but 56% of respondents of rural areas had given plain water and no respondents were (in urban and rural) given rice water. So this literature partially supports this research study.
 9. Edet (1995) stated that only less than half of children were continued breast-feeding. But the findings of the present study shows that most of (84%) respondents from urban and 92% of respondents from rural areas were giving breast milk during diarrhea and among them cent percent of urban respondents and also sent percent of rural respondents were continuous breast feeding during diarrhea. So this literature not supports this research study.
 10. Ahmed et al. (2000) stated that only one-third mothers (33.3%) were able to the packet ORS solution correctly. But the findings of the present study shows that majority of parents (both in urban and rural) have had knowledge about jeevanjal, its preparation and amount of water to needed. So this literature not supports the present study.
 11. National diarrhoeal disease controlled programme, HMG Nepal (1996), stated that 18% of the episodes with hold food and 65% received less than usual. But finding of this study shows that majority of (92%) respondents in urban and 76% of respondents in rural were giving additional food during diarrhea and only 24% of respondents in rural and only 8% of respondents in urban with holding food. Among then 47.83% of urban respondents were given food as more than usual but 31.57% of rural respondents were given food per child's demand. So this literature is partially support this research study.

12. The literature No. 8 (of predisposing factor) stated that the incidence of diarrhea is increased during measles. Measles associated diarrhea is often severe and of longer than usual durations. But during this study, among 50 children (from urban & rural) no any have had suffered from measles. This literature not supports this research study even if is true that measles associated diarrhea is often severe. But measles children are being treated in Teku hospital not Kanti children hospital so it might have been due to this reasons.

5.4 Acceptances and Rejection of Hypothesis:

The hypothesis was, " the knowledge and practice regarding home care of children during diarrhea would be better in urban parent than in rural parents"

Hypothesis of this research study is rejected because of not significantly different of knowledge and practice of rural parents in comparison to urban parents. It might be due to their educational status, residence of rural parents because most of all rural parents were from inside the Kathmandu valley where all facilities like communications (electronic newspaper, advertisement) and transportation are already available than in rural areas out of Kathmandu valley. A part from this course of rejection hypothesis might be their snaking answer or astuteing answer because practice item was also conducted by direct interview method rather than observation.

5.5 Recommendation, for future study

1. A similar type of study can be conducted in a large number of samples to draw better generalization.
2. A descriptive type of study in rural community may be very useful.
3. A comparative study can be done between illiterate and literate parents.

5.6 Implication of the study

1. This study may be useful for health personnel who work in the ORT, Medical OPD and in the community in order to provide effective health education with emphasis on dangerous complication, quality and quantity of food/ fluid during diarrhea.
2. The investigator hopes that this study will be helpful to all people who are more terested to obtain knowledge about home management of children under five during diarrhea.

This study will help to differentiate between care of children of urban parents and rural parents then will help to prepare the future plan.

4. This study will help the nurse researcher to select further topics for research in diarrhoea.
5. It will help to health care planner to some extent to plan and carry out preventive and curative health services.

APPENDIX

T.U.I.O.M.

Nursing Campus Maharajgunj Post-Basic Bachelor of Nursing Programme Interview questionnaires

Objectives: To assess the knowledge and practice of parents about the care of children during diarrhoeal episodes to their under five year children.

Direction: The following questions will be asked to each respondent after taking verbal permission. The respondents will not be forced to give answer. The data will be kept confidential and will be used for the research study.

Date of data collection:

Place of data collection:

Information: Father/Mother

PART 1

A. Demographic data of the child.

1. Age of the child
 - a) 6 Months to 2 years
 - b) 2 to 3 years
 - c) 4 to 5 years

2. Sex of the child
 - a) Male
 - b) Female

3. Onset of diarrhoea
 - a) 1 – 3 days
 - b) 4 – 7 days
 - c) Above 7 days

4. Degree of Dehydration
 - a) Mild

- b) Moderate
- c) Severe

5. Frequency of hospital visit

- a) First time
- b) More than 1 time

B. Demographic data of the parents

1.1 Age of the mother

- a) 15 to 19 years
- b) 20 to 24 years
- c) 25 to 29 years
- d) 30 to 39 years
- e) Above 40 years

1.2 Education of mother

- a) a) Illiterate
- b) Class 5
- c) Class 6 to class 10
- d) Certificate level
- e) Diploma and more

2.1 Age of father

- a) 15 to 19 years
- b) 20 to 24 years
- c) 25 to 29 years
- d) 30 to 39 years
- e) Above 40 years

2.2 Education of father

- a) Illiterate
- b) Class 5
- c) 6 class to 10 class
- d) Certificate Level
- e) Diploma and above

1.1 Occupation of mother

- a) House wife
- b) Service
- c) Business
- d) Agriculture

1.2 Occupation of father

- a) House wife
- b) Service

- c) Business
- d) Agriculture
- 4. Number of Children (Parity)
 - a) One
 - b) Two
 - c) Three and more
- 5. Residence
 - a) VDC
 - b) Nagerpalika
 - c) Mahanagerpalika
- 2. Religion
 - a) Hindu
 - b) Buddha
 - c) Christian
 - d) Muslim
- 7. Types of family
 - a) Nuclear
 - b) Joint
- 8. Ethnicity
 - a) Brahamin
 - b) Chhetry
 - c) Newar
 - d) Magurali
 - e) Others
- 9. Economic Condition
 - a) Not enough for daily expenses
 - b) Only enough for daily expenses
 - c) Extra saving

PART II

A. Knowledge Items

Q.N. 1. What do you mean by diarrhoea?

- a. Three or more than three times watery stool in a day.
- b. Semi solid stool.

- c. One time watery stool in a day.
- d. Others

Q.N. 2. In your opinion, what are the causes of diarrhoea?

- a. Evil spirit
- b. Polluted food and water.
- c. Due to cold.
- d. Teething.
- e. Others.

Q.N.3. In your opinion, who is the most risk person from diarrhoea?

- a. Under five children.
- b. Young adult.
- c. Old.
- d. All person.
- e. Others

Q.N.4. In your Opinion, Is diarrhoea communicable disease?

- a. Yes
- b. No
- c. Do not know

Q.N.5. In your opinion, what types of diseases is diarrhoea?

- a. Simple
- b. Danger
- c. Both

Q.N.6. In your opinion, can we prevent diarrhoea or not?

- a. Yes
- b. No

If Yes How?

Q.N.7. Is it better to give food to the child during diarrhoea?

- a. Yes
- b. No

If Yes What types of food is better during diarrhoea?

- a. Liquide
- b. Solid
- c. As Usual
- d. Others

Q.N. 8. What is the fluid (Liquid) can be given to the child during diarrhoea?

- a. Jeevan Jal
- b. Dal ko jhol
- c. Gedagudiko jhol
- d. Others

- Q.N.9. In, which condition, the child must be taken to the Hospital?
- a. Uncontrolled diarrhoea even good home management.
 - b. Continuous Vomiting
 - c. Blood in stool.
 - d. Others.

- Q.N.10. Do you know, about the complication of diarrhoea?
- a. Yes
 - b. No

If yes what are the complication of diarrhoea?

1.....

2.....

- Q.N.12 Do you know about Jeevan jal?
- a. Yes
 - b. No

A. *If Yes, What types of water should needed for preparing Jeevan Jal*

a. *Boiled Than cooled water in clean pot.*

b. *Warm water.*

c. *Tape water.*

d. *Others*

B. *Do you know, how much water should be mixed with a Jeevan Jal Packet?*

a. *One glass*

b. *Half liter*

c. *Six full tea glass of water or one liter*

d. *Others*

C. *After preparing of Jeevan Jal at once, how long it can be saved?*

a. *Only six hours*

b. *Till it finishing*

c. *Only 24 hours*

d. *Others*

B. Practice Item

- Q.N.1. Did you give additional water to the child during diarrhoea?
- a. Yes
 - b. No

If Yes, What types of water did you give?

a. *Plain water*

b. *Jeevan Jal*

- c. *Glucose*
- d. *Others*

Q.N.2. How frequently did you give water to the child during diarrhoea?

- a. 2 to 4 times
- b. 4 to 6 times
- c. When baby is demand
- d. After each episode diarrhoea

Q.N.3. Are you breast feeding to this child?

- a. Yes
- b. No

A. *If Yes, Did you continue breast-feeding during diarrhoea?*

- a. *Yes*
- b. *No*

A.1.. *If Yes, how frequently did you breast feeding your child during diarrhoea?*

- a. *As usual*
- b. *Less than usual*
- c. *More than usual*

Q.N.4. Did you give addition food to the child during diarrhoea?

- a. Yes
- b. No

A. *If Yes, What kinds of food did you give to the child during diarrhoea?*

- a. *Jaulo*
- b. *Dalko jhol*
- c. *Gedagudiko Jhol*
- d. *Others*

B. *How much of this food did you give to the child during diarrhoea?*

- a. *As usual*
- b. *Less than usual*
- c. *More than usual*
- d. *Others*

C. *If No, Why didn't you give food to the child during diarrhoea?*

- a. *Due to indigestion*
- b. *Due to vomiting*
- c. *Child refuse*
- d. *Others*

Q.N.5. Where did you dispose your child's diarrhoeal excreta?

- a. Toilet
- b. Open field
- c. River
- d. Others

Q.N.6 Did you clean your hands after disposing the excreta?

- a. Yes
- b. No

A. *If Yes, How did you clean your hands after disposing the excreta?*

- a. *With soap and water*
- b. *With ash and water*
- c. *With mud and water*
- d. *Others*

B. *If No, Why didn't you clean your hands?*

- 1.....
- 2.....

Q.N.7. Did you clean your child's anus after each defecation during diarrhoea?

- a. Yes
- b. No

If Yes, What materials did you use for cleaning the child's anus?

- a. *Water*
- b. *Pieces of old clothes*
- c. *Paper*
- d. *Others*

Q.N.8. What is the causes for visiting this child to the Hospital?

- 1.....
- 2.....

Q.N.9 have you consult any where before visiting to the Hospital?

- a. Yes
- b. No

If Yes, Who were they?

- a. *Health personnel*
- b. *Dhami Jhankri*
- c. *Others*

CONSENT

Heading: Care of children during the diarrhoea among the parents of under five years children.

My name is Sabitri Kumari Paudel. I am a nurse and a student of Bachelor of Nursing Programme at Nursing Campus Maharajgung, Kathmandu. Now I am doing research in the topic of “*Care of children during diarrhoea*” and during my research I am going to ask some questions on this topic to those parents whose children are coming for treatment of diarrhoea in Kanti Children Hospital.

If you agree with me, I will take only 15-20 minutes for interview. During interview, please, I request you to feel free and also feel free to withdraw yourself if you feel tired and are not interested to give the answer. It will be confidential.

This interview is not directly beneficial to you and also will not effect in your treatment. But it will help you in the future how to care your children at your home while the children is suffered from diarrhoea.

Sabitri K. Poudel

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RESEARCH WORK PLAN

SN.	Activities	Month	Baisakh			Jestha			Ashad
			Weeks	1	2	3	4	5	6
1	Review of literature								
2.	Proposal Writing								
3.	Tool Preparation and pre-testing								
4.	Data Collection								
5.	Data Analysis								
6.	Data Interpretation								
7.	Reporting Writing								