



Assessment of caregivers knowledge of diarrhoea and practice of home management of diarrhoea disease among under two children in Opialu, a rural community in Benue State, Nigeria

Gabriel Ofikwu Ogbeyi^{*1}, Adu Onyemochu¹, Chikaike Ogbonna¹

ABSTRACT

Background

Diarrhoeal disease is a major cause of childhood morbidity and mortality in developing countries. Knowledge, attitudes, beliefs and practices of the caregivers are important determinants of the occurrence and outcome of diarrhoeal disease. This study assessed the care givers knowledge of diarrhoea and practice of home management of diarrhoea diseases in under- two children in Opialu, a rural community in Benue State, Nigeria.

Methods

A descriptive cross sectional study was employed on 295 nursing mothers in Opialu Benue State, Nigeria via a systematic random sampling technique. They were interviewed using pre-tested semi-structured interviewer administered questionnaires. Data were analysed using Epi Info, version 3.3.1.

Results

The mean age of the respondents was 26.7 (SD \pm 7.5) years. One hundred and twenty six respondents (42.7%) could define diarrhoea correctly, 201 (68.1%) identified teething as the cause of diarrhoea, while 32 (10.9%) opined germs to be the cause of diarrhoea among under two children. More than half (61.1%) of the respondents had correct knowledge of hand washing after using the toilet, 215 (72.9%) practised several methods of home management of diarrhoea diseases and 70 (23.7%) of respondents had adequate immunization for the child's age.

Conclusion

The knowledge of diarrhoea diseases amongst under two care givers in the study area was poor and they had inappropriate home management practices of the diseases, hence the caregivers in rural communities need to be educated and trained on home management of diarrhoea diseases in order to reduce the mortality and morbidity.

Keywords: Caregivers, Diarrhoea, Home Management, Rural, Nigeria

INTRODUCTION

Caregivers have wide scope of definitions, which according to the American Heritage Dictionary is an individual who attends to the needs of a child or a

dependent adult. These include: biological parents, foster parents, or head of a household.¹ The definition also covers a physician, nurse, or a social worker, who assists in the identification, prevention, or treatment

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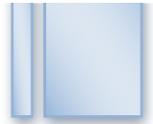
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of an illness or disability.¹ The choice of mothers as a group of caregivers to be studied in this work was because diarrhoea in children which these mothers manage rank highest in terms of public health importance compared to health problems managed by other caregivers.²

Diarrhoea is defined as a passage of three or more loose or watery stools in twenty-four hour period.² Acute diarrhoea is rivalled only by respiratory infection, as a cause of morbidity on a worldwide scale.² When the World Health Organization (WHO) initiated the diarrhoea disease control programme in 1980, approximately four million children were dying each year of dehydration caused by diarrhoea.³ The total diarrhoea morbidity for a given child may be as high as one third of its first two years of life.^{3,4} In some tropical countries 15-40% of all deaths among children under 5 years are due to diarrhoea.⁴ Diarrhoea is a major public health problem in developing countries. An estimated 1.8 billion episodes of diarrhoea occur each year and 3 million children under the age of 5 years die of diarrhoea; 80% of these deaths affect children under the age of two years.⁵ Episodes are generally associated with other infectious diseases, making treatment and prevention more difficult.¹⁻⁴

Home treatments are an essential part of the correct management of acute diarrhoea diseases.³ This is because in most communities diarrhoea disease patients received home or self-treatment first since this is the cultural practice in by most communities.^{5,6} In the case of diarrhoea in children, the disease begins at home and children seen at a health facilities usually continue to have the episode after returning home. Studies have shown that caregivers are the first to recognize diarrhoea, hence the decision to seek care is made within the home.⁷ Studies have also reported that diarrhoea is commonly managed at home using orthodox and herbal medicines.^{5,7} When orthodox treatments are given at home, dosages are often incorrect and inadequate.⁶ The use of health centres as the first resort for diarrhoea management has been shown to be low in many African studies including Nigeria.⁸

A review of caregivers diarrhoea treatment seeking behaviour in rural northern Nigeria revealed that more than 80% of diarrhoea episodes received treatments outside of the existing government health care system.^{9,10} These treatments are usually incorrect or sub-optimal.^{11,12} This practice increases morbidity and mortality in addition to contributing to possible emergence of danger signs in diarrhoea disease.¹³ Therefore, children must receive proper treatment at home for diarrhoea if dehydration and nutritional damage are to be prevented.² Mothers who understand home treatment should begin before seeking medical care because when 'early home therapy' is given, dehydration and nutritional damage can be prevented.³

Even though most caregivers act as "doctors" in the event of childhood illnesses before any external intervention, studies conducted in several parts of the world showed that a large percentage of children die at home because their parents and caregivers cannot recognize the signs of common childhood illnesses and therefore do not seek appropriate care.^{14,15} Parents and caregivers also lack the skills to administer life-saving home treatment, such as oral rehydration therapy to children with diarrhoea.¹⁶ Poor knowledge and poor sense of self-reliance in managing a child's diarrhoea have been reported in other studies.^{17,18} This study assessed care givers knowledge of diarrhoea and practice of home management of diarrhoea diseases among under two children in Opialu, a Rural Community in Benue State, Nigeria.

METHODS AND MATERIALS

Study Area

The study was community-based, conducted in Opialu, a rural setting in Okpokwu Local Government Area (LGA) of Benue State, Nigeria. This study was conducted from July through September 2014. Opialu is located about three hundred kilometers South of Makurdi, the capital of Benue State, in north central Nigeria. Opialu is the largest village in Okpokwu LGA with an estimated population of 10,648 people (projected from 2006 census).⁹ The inhabitants of Opialu are predominantly farmers and the majority are Christians. The people of Opialu have a common language, the Idoma language which serves as the



medium of communication. The topography of Opialu is that of Guinea Savannah. River Okpokwu which flows throughout the year is their source of water. Few individuals have wells in their compounds. Majority of the people in the community have poor sanitary conditions. Only a few have pit latrines while majority defecate in the bush. There is a Local government Primary Health Care facility located within the community. There is a comprehensive health centre built in Ojigo about fifteen kilometers from Opialu by the Federal Government of Nigeria. Okpokwu River with a local bridge built of wood by the communities will have to be crossed before Opialu can access the health centre. The road linking the two communities is untarred and difficult to pass during rainy season. There is one public primary school in Opialu village with population of 220 pupils.

Study Population and Design

A cross-sectional, community- based, descriptive study design was employed for the study. The study population consisted of caregivers and their children between 0-24 months living in Opialu at the time of the study. The mothers of the under-two children were chosen for this study, reasons being that diarrhoea in children which these mothers manage rank highest in terms of public health importance compared to health problems managed by the other caregivers.² Caregivers with children aged 0-24 months at the time of the study living in Opialu were selected. Households without caregivers with children 0-24 months at the time of the study were excluded. Eligible caregivers who did not consent were also excluded from the study.

Sample Size Determination

All households in the village were listed using already existing primary health care numbering of the area for recruitment of the study subjects. The sample size was determined using the formula

$$n = \frac{Z^2 p (1-p)}{d^2} \quad ^{19}$$

with assumption of 50% of the target children in the community assumed to have developed at least an episode of diarrhoea diseases in their life time, 5% tolerable margin of error at 95% confidence interval,

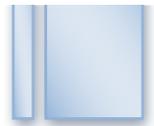
and considering attrition rate of 10%, the minimum sample size of 295 was arrived at.

Sampling Technique

A systematic sampling technique was used to select the respondents after determining the sampling interval until the desired sample size was obtained. The selection was based on the estimated population statistics obtained from the LGA head office before the commencement of the survey. The village was mapped and numbered and one thousand six hundred and fifty five households (1655) households were identified and the actual list of the households was used as the sampling frame. Sampling interval of 5 was calculated and used for the selection of households. A household is defined as people eating from a common pot. A compound may include many households. The first household was selected using a table of random numbers and the subsequent households were selected by the calculated systematic intervals of five. Once a household is selected, five households next to the surveyed one were excluded and the movement was maintained continuously to the right side. In situations where the research assistants arrived at the same house again, they turn to the left and continue sampling until the minimum sample size was obtained. Where there is more than one household in a compound, only one was selected by simple random sampling using a table of random numbers. In situations where an eligible caregiver in a household was absent, a repeat visit was conducted by research assistants for three consecutive times before a replacement would be considered. Such households were revisited at specified periods when they were probably assumed to be present.

Data Collection

Structured questionnaire was administered in the local dialect to each caregiver by the investigators and trained assistants. Parameters covered by the questionnaire included age, occupation, level of education, family size, number of children, husband's occupation and level of education, her definition of diarrhoea and possible causes. Other information obtained include: symptoms of diarrhoea, diarrhoea mortality, danger signs of diarrhoea, oral rehydration



solution, hand washing, immunization, breast feeding and sanitary methods of refuse disposal.

Statistical Analysis

All data generated were processed and analysed by EPI info version 3.3.1, an epidemiological software programme for testing proportions and calculation of means. Data were summarised and presented as frequency tables and charts. Chi-square (χ^2) test was used to test for statistical relationship between proper home management of diarrhoea diseases, knowledge in children by caregivers and acceptance of good practices. A confidence interval of 95% was used in this study and a p-value of equal to or less than 0.05 was considered statistically significant. Regarding knowledge on diarrhoea disease, there were 14 questions, all correct responses were awarded one mark and incorrect answers were awarded a zero

mark. The scores are summed and graded in percentage; 0-34% was classified poor, 35- 68% was classified as fair and 69-100% was classified as good knowledge score.

RESULTS

Socio Demographic Characteristics of the Respondents

Table 1 represents the socio-demographic characteristics of the respondents and the under two children who were taken care of by the respondents. Of the total 295 caregivers recruited for the study, their mean age was 26.7(SD± 7.5) years. Two hundred and forty (81.3%) of them were farmers, 228(76.0%) had completed primary education and 291(98.8%) were Christians. The mean age of the children was 10.2(SD ± 7.6) months and the distribution of the index children was 52.2% (female) and 45.1% (male).

Table 1 Socio Demographic Characteristics of Respondents (n=295)

Features	Frequency	Percent
Age (years)		
<20	46	15.5
20-29	145	48.7
30-39	81	27.7
40-49	23	7.9
Marital status		
Married	261	88.4
Single	26	8.8
Widowed	5	1.8
Divorced	3	1.1
Religion		
Christianity	291	98.8
Islam	4	1.2
Educational status		
None	16	5.6
Primary	228	76.0
Secondary	48	17.4
Tertiary	3	1.0
Occupation		
Farming	240	81.3
Civil servant	6	1.9
Student	15	5.3
Trader	28	9.4
Applicant	3	0.9
House wife	4	1.2
Mean ± (SD)	Age of caregiver (years)= 26.72 (SD ±7.52)	
	Age of children (months) = 10.15 (SD ± 7.59)	

Knowledge of Diarrhoea



Table 2 shows knowledge on definition of diarrhoea in a child, causes, ways of contracting the disease oral rehydration solution and anti-diarrhoeal agents. One hundred and twenty six (42.7%) of the respondents had fair knowledge of the correct definition of diarrhoea in a child, while 57.3% had poor knowledge of the definition of diarrhoea. On the causes of diarrhoea in a child, a high proportion of respondents 201(68.1%) identified teething as a major cause of diarrhoea. Some misconceptions such as sun and jedijedi 130 (43.1%) were indicated as causes of diarrhoea by the caregivers. Germs were identified by 32(10.9%) as causes of diarrhoea. On ways of contracting diarrhoea in a child, 69(23.4%) of the

respondents opined breast feeding as one of the ways a child could contract diarrhoea. Overall, the respondents generally had poor knowledge on the causes of diarrhoea. Forty (13.6%) opined that contact with another person is a recognized route in which a child could get diarrhoea. The most common measures mentioned for managing diarrhoea at home was mist kaolin 189(64.1%) and metronidazole 175(59.3). A fair knowledge of anti-diarrhoea drugs and ability to name at least one drug was observed. The result also showed 210(71.2%) of caregivers were aware of ORS.

Table 2 Knowledge on Definition, Causes and Ways of Contracting Diarrhoea, ORS and Anti-diarrhoea Agents

Feature	Grading (%)	Frequency	Percent
Definition of Diarrhoea			
Correct	Fair (35-68)	126	42.7
Incorrect	Poor (0-34)	169	57.3
Causes of Diarrhoea			
Teething	Poor (0-34)	201	68.1
Contaminated water	Poor (0-34)	82	28.0
Contaminated food	Poor (0-34)	79	26.8
Germs	Poor (0-34)	32	10.9
Others	Poor (0-34)	130	44.1
Ways of contracting diarrhea			
Contaminated water	Poor (0-34)	101	34.2
Contaminated food	Poor (0-34)	89	30.2
Breastfeeding	Good (35-68)	69	23.4
Contact with another person	Good (35-68)	83	28.3
Others	Good (35-68)	40	13.6
Able to name at least one anti diarrhoea agent			
Yes		140	47.5
No		155	52.5
If yes, which one;			
Metronidazole		175	59.3
Mist Kaolin		189	64.1
Ever heard of ORS			71.2
Yes		210	28.8
No		85	



Table 3 is about respondent’s knowledge of sanitary methods of disposing faeces and critical times of hand washing. Respondents had mixed responses in the knowledge of proper sanitary methods of disposing faeces. They had a good knowledge that disposing faeces in a pit latrine was correct 203(68.8%). They also had good knowledge that rising away children’s faeces while washing was incorrect 192(65%). However, 76.9% had poor knowledge that throwing faeces outside the yard was a proper method of sanitary disposal. Majority (61.1%) of the respondents’

opined that it was proper to wash their hands after using toilet, 118(40.0%) opined that it was proper to wash their hands after attending to a child that defecated, 24(8.0%) of the respondents washed their hands before feeding their children. The most common measures mentioned for managing diarrhoea at home was mist kaolin 189(64.1%) and metronidazole 175(59.3). A fair knowledge of anti-diarrhoea drugs and ability to name at least one drug was observed. The result also showed 210(71.2%) of caregivers were aware of ORS.

Table 3 Knowledge on Sanitary Methods of Disposing Faeces and Critical Times of Handwashing (n=295)

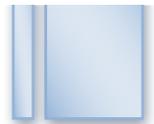
Feature	Grading (%)	Frequency	Percent
Disposed of in a latrine	Good (35-68)	203	68.8
Thrown outside yard	Poor (0-34)	227	76.9
Rinsed away while washing	Good (35-68)	103	35.0
Critical times of hand washing			
After using toilet	Good (35-68)	180	61.1
After attending to a child that defecated	Fair (35-68)	118	40.0
Before feeding a child	Poor (0-34)	24	8.0

Table 4 shows practice of home management of diarrhoea and hand washing. A high proportion of caregivers (72.9%) practiced home management on their children. Majority (93.2%) of the respondents did not wash their hands with soap and water when child’s faeces were disposed, while 20(6.8%) of the

caregivers washed their hands with soap and water the last time the child defecated. Thirty-two (10.8%) washed hands with soap and water before cooking. Over 195(65%) of the respondents managed the index child with anti-diarrhoeal agent last time child had diarrhoea while only 103(34.9%) gave more ORS.

Table 4 Practice of Home Management of Diarrhoea and Hand Washing (n=295)

Variable	Frequency	Percent
Practice home Management of diarrhea		
Yes	215	72.9
No	80	27.1
Wash hands with soap and water when child’ faeces was disposed		
Yes	20	6.8
No	275	93.2
Wash hands with soap and water after defecation		
Yes	89	30.2
No	206	69.8
Wash hands with soap and water before cooking		
Yes	32	10.8



No	263	89.2
Give more ORS		
Yes	103	34.9
No	192	65.1
Give anti- agent		
Yes	195	66.1
No	100	33.9

Table 5 shows caregivers practice of immunization and nutrition. It was observed that over 84.4% of the index children had initial immunization. In the case of a child having adequate immunization, 23.7% of the index children had appropriate immunization for their

age as compared to 76.3% with inadequate immunization scheduled for their age. Majority (95.3%) of the respondents had breastfed their children in the past, but the practice of exclusive breast feeding among the respondents was low (2.4%). More than half (61.0%) of the respondents give more fluids to their children during episodes of diarrhoea disease.

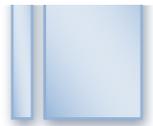
Table 5 Practice of Immunization and Nutrition

Variable	Frequency	Percent
Index child immunized?		
Yes	250	84.7
No	45	15.3
Child with adequate immunization for age?		
Yes	70	23.7
No	225	76.3
Ever breast fed your child?		
Yes	281	95.3
No	14	4.7
Practiced exclusive breast feeding for index child?		
Yes	7	2.4
No	288	97.6
Restricted foods during last diarrhoea episode		
Yes	44	14.9
No	251	85.1
Restricted breast feeding during last diarrhoea episode		
Yes	30	10.2
No	265	89.8
Give more fluids		
Yes	180	61.0
No	115	39.0

DISCUSSION

Some socio-demographic characteristics of the caregivers in our study are consistent with findings

from other studies in Nigeria while some are at variant. For instance 81% of the caregivers in our study were farmers. The figure was higher than the 75%



recorded in a similar study in Kaduna state, Nigeria.²⁰ The figure was also far higher than the 9% recorded in Enugu, Nigeria.²¹ Nigerian is predominantly an agrarian culture but the variation between our study and the study conducted in Enugu could be probably due to the site, Enugu been a highly urbanized city and as such the caregivers had more opportunities of engaging in other employments apart from subsistence farming. The literacy level of caregivers in our study is far higher than the national average of 64.1%.^{17, 21} This finding can be used as an opportunity for proper education on management of diarrhoea disease among care givers.

In our study, the overall knowledge score with respect to definition of diarrhoea disease, causes, ways of contracting diarrhoea disease, sanitary methods of disposing faeces and critical times of hand washing was poor. This was lower than the findings of other studies done in Matlab, Bangladesh.²¹ Studies have shown that knowing what constitutes diarrhoea disease will improve health seeking behaviour of the caregivers and prompt treatment.²¹

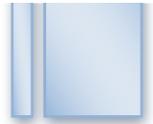
Regarding causes of diarrhoea diseases, teething as a major cause considered by 68% of caregivers in our study is worrisome. This agreed with other studies done in Nigeria,²⁴ in central Thailand³¹ and in India.²⁵ It is true that the incidence of diarrhoea is higher in infancy (during teething and crawling period).¹⁶ This apparent association is because there is peca associated with this stage of growth and development which predisposes the child to ingestion of diarrhoeal pathogens. To curb this problem, caregivers need to keep their environments clean especially sanitary disposal of refuse and faeces. There should be proper supervision of nannies so that they look after the children properly. This will bring about swift intervention any time the child is going to swallow peca. In this study 10-28% of the respondents believed that germ, contaminated water and contaminated food were causes of diarrhoea in childhood. These believes about germs, food and water causing diarrhoea cut across the major ethnic groups in Nigeria.²⁴⁻²⁶

Amongst the several ways such as contaminated water, contaminated food, contact with another

person and jedi jedi as means of contracting diarrhoea disease; the most worrisome in our study is the opinion by the caregivers that breast milk causes diarrhoea disease. This finding is consistent with report from other studies in Nigeria,^{26, 27} but breast milk is inimical to survival in childhood. Breast milk intake is the corner stone of feeding during early infancy. Breast milk meets all of an infant's nutritional requirements for the first six months of life and is superior to any substitute. It confers several benefits on both infant and mother, the most important of which is its protective effect against infections such as gastrointestinal and respiratory infections in the infant.²⁶⁻²⁸ The finding in our study may pose threat to practise of exclusive breastfeeding advocated by UNICEF as an important component of child survival strategies for children.

In terms of home management of diarrhoea disease by caregivers the findings that over 70% of the respondents had heard of ORS/SSS in the present study is encouraging. This finding is comparable with other studies done in Nigeria,²⁶⁻²⁸ Guinea-Bissau²⁸ and India.²⁹ Complete lack of knowledge of ORS/SSS has profound impact on the management of diarrhoea disease by the caregivers.^{4, 26} This suggested an inadequate interaction between a caregiver and a health worker. Due to complete lack of knowledge by a caregiver of ORS/SSS she will not seek it in a case of her child having diarrhoea. Likewise, uneducated mothers were also likely to be completely unaware of ORS/SSS.^{4, 26} The caregivers in this study had poor knowledge on the uses of ORS/SSS in the management of diarrhoea disease in childhood at home. This is surprising since a high percentage of caregivers were aware of ORS/SSS. This agreed with other studies done in Nigeria^{8, 26} and Columbia.⁴ Caregivers had misconception about the uses of ORS/SSS in diarrhoea treatment. Caregivers may have some traditional belief that sugar can cause Jedi-Jedi. This showed that traditional beliefs can be serious impediment in the use of ORS/SSS.^{4, 20}

Majority of the caregivers practised home management of diarrhoea disease in their children. This is because caregivers serve as the first 'doctor' any time their children had diarrhoea.^{4, 6} It was observed from other studies that the first action taken



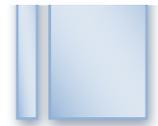
by caregivers in the management of diarrhoea disease at home is the use of anti-diarrhoea agents.^{4,11} The most frequently used anti-diarrhoea agents in this study were metronidazole and mist kaolin. The 66% frequency of anti-diarrhoea agents used in this study is comparably higher than 54% anti-diarrhoea agents recorded in a study at Ilorin, Nigeria.¹⁵ The source of procurement of the drugs varies widely, but the role of chemist shops/pharmacies, roadside vendors, and health institutions in supply of drugs is notable. If these remain the sources of therapy of inappropriate anti-diarrhoea agents, any health education intervention that emphasizes appropriate replacement of fluid losses - rather than the use of anti-diarrhoeal agents is likely to fail.^{4, 31} Therefore, the intervention must involve health education of drug vendors and health workers. The care givers in rural areas should be encouraged to promote the use of ORS rather than anti-diarrhoea except when indicated as a life saving measure

Most caregivers in this study had poor home management practices in respect of diarrhoea disease. A good proportion of them did not wash their hands with soap and water when child's faeces were disposed of, after defecation and before cooking. In a similar way over 31% of caregivers indicated that disposing faeces in a latrine and rinsing away faeces while washing were correct practices. This is disturbing because sanitary methods of faecal deposition has been reported to having a significant relationship with diarrhoea disease.²¹ Studies done in Northeast Brazil and Bangladesh showed that provision of improved latrines reduced diarrhoea episodes and also changed attributable and relative risks from 24% to 13%.^{21, 24} The study in Punjab, Pakistan also showed significant association between diarrhoea and toilet facilities.^{13,21} Other environmental issues that contributed to high diarrhoea are unsafe drinking water and poor refuse disposal. These communities depended 100% on running surface water, and open dumping as the means of refuse disposal. Unsanitary toilet facilities and highly contaminated water sources are major contributors to high diarrhoea prevalence.^{13, 21}

Over 80% of the care givers commenced immunization in their children preceding this study

but only about 23% had adequate immunization for their age. A study done in Peru revealed that children who had measles, or had had the disease in the previous four weeks, had a substantially increased risks of developing severe or fatal diarrhoea or dysentery.^{11,13} Measles vaccines given at the recommended age can prevent up to 25% of diarrhoea associated deaths in children under five years of age.¹³ In other studies done in Mexico and Nicaragua, pentavalent rotavirus vaccine (TVS) was associated with a lower risk of severe rotavirus diarrhoea in children younger than two years.^{29, 32} The Federal government of Nigeria in conjunction with WHO and UNICEF had tried to strengthen routine immunization in Nigerian which is less than 30% coverage.³³ The Expanded Programme on Immunization was launched in 1979 and restructured in 1997 as National Program on Immunization. Supplementary catch-up campaigns were planned and regularly carried out to improve routine immunization coverage. Also multi-antigen campaigns to reduce the number of contacts required to complete the immunization series by simultaneous administration of two or more antigens during a single visit were introduced.³³

The findings in this study that 92% of the caregivers continued breastfeeding during diarrhoeal disease compared favourably with the Ikara study in Kaduna state in Nigeria.²⁰ It contrasted another study done in Enugu where 75% of the caregivers taught that breastfeeding during diarrheal episodes could harm their children.²² Other dietary measures where that over 90% of caregivers practiced giving more food during diarrhoeal attacks and this was similar to some studies done in Tanzania.^{3, 31} The limited restrictions carried out during diarrhoeal diseases in feeding practices was due to the belief by the nursing mothers that giving more fluids or diet may increase more diarrhoea in their children. Presence or absence of diarrhoea in children is related to exclusive breast feeding. A study done by UNICEF in Nigeria collaborated this. This study revealed that during the first six months of life, the risk of having severe diarrhoea that required hospitalization could be 30 times greater for non-breast fed infants than for those who were exclusively breast fed.¹ Other studies done in Brazil showed that diarrhoea prevalence was reduced by 21% among caregivers that breast fed



their children.^{21, 18} In another study in Bangladesh it was shown that infants breast fed from birth to six months of age had a significantly lower prevalence of diarrhoea than those who were not exclusively breast fed.¹⁷

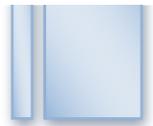
The rate of exclusive breastfeeding in this study was less than 5%. This rate is far lower than the 15-17% rate for 6 months exclusive breast feeding in Nigeria.³³ The finding is however comparable to a survey done in the country with exclusive breast feeding rate of 7.9%.¹⁷ The communities believed that children must be given water few hours after delivery. There was also the rejection of colostrum on the ground that it made their babies sick. Issues of problem of peer pressure were there. Majority of the caregivers preferred to conform with the practices in their communities.^{17, 33}

CONCLUSION

Care-givers knowledge on the various parameters assessed such as, definition of diarrhoea, causes, and ways of contracting diarrhoea are poor. The practices shown by the caregivers home management of diarrhoea with regard to hand washing, sanitary disposal of faeces, immunization, and nutrition, were inappropriate and below standard. The best approach of reducing diarrhoea morbidity and mortality in this community is through capacity building by employing health education programmes on the care-givers.

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