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Original Research Article

Knowledge regarding management of diarrheal disease among mothers of under five children: a cross-sectional study

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ABSTRACT

Background: Diarrhoea is defined as the passage of loose or watery stools more than three times per day. It remains a major cause of childhood mortality and morbidity, particularly among children under five years of age. Mothers, being the primary caregivers, play a crucial role in the prevention and management of diarrhoeal diseases, and their level of knowledge significantly influences child health outcomes. Objectives were to assess knowledge regarding the management of diarrhoeal disease among mothers of children under five attending a teaching hospital in Pokhara.
Methods: A descriptive cross-sectional study was conducted at Gandaki Medical College Teaching Hospital and Research Center (GMCTHRC), Pokhara, Kaski. The study population included mothers of children aged six months to five years attending the paediatric outpatient department. A non-probability convenience sampling technique was used. Data were collected through a structured interview schedule and analysed using SPSS version 16. Descriptive statistics (frequency, percentage, mean, standard deviation) and inferential statistics (chi-square test) were applied.
Results: More than half of the respondents (58.6%) were older than 29 years. The majority (97.1%) correctly identified diarrhoea as the passage of loose, watery stools more than three times daily. Overall, 55.7% of mothers had good knowledge, 41.4% had average knowledge, and 2.9% had poor knowledge regarding diarrhoeal disease management. No significant association was found between knowledge level and demographic variables.
Conclusions: More than half of the respondents demonstrated good knowledge regarding diarrhoeal disease management. However, targeted health education interventions are recommended to address remaining knowledge gaps among mothers of under-five children.

Keywords: Diarrhoea, Diarrheal management, Knowledge, Mothers, Under five

INTRODUCTION

Diarrhea is loose, watery stools that occur more than three times a day are caused by bacteria, viruses, parasites.[1] acute diarrhea is an attack of sudden onset, which usually lasts for 3-7 days, but may last up to 10-14 days.[1] chronic diarrhea starts as an acute episode and lasts for more than 2 weeks.[1] untreated diarrhea as a result cause severe dehydration and that leads to fluid loss and may be life threatening particularly in young children (3-5 years) who are malnourished or have impaired immunity.[2] rehydration is a cornerstone of treatment of diarrhea to prevent dehydration.[3]

Globally, diarrhea disease remains the second leading cause of death among under five years children about 1.6 million death occurs each year nearly 1 in every 5 deaths.[4] The Rota virus is the leading cause of about 40% of hospitalization for diarrhea in children under five years

of age.[5] Rota virus is associated with approximately one third of diarrhea death and can only be adequately prevented through vaccination.[6] Although water, sanitation and hygiene related intervention have been found to successfully reduce the global burden of diarrhea, vaccination has been reported as the strongest protection against vaccine preventable causes of diarrhea among children among under five years globally.[7]

In developing countries, most diarrheal episodes are treated at home, and mothers are the primary health care providers for children under five years.[8] Under five children's mothers are the ones who decide about the type of food given to the child and the overall management of the disease.[8] In India about 1.5 million under-fives out of total 18 crore die every year due to acute gastroenteritis.[9] If little care is provided with the onset of diarrhea and oral rehydration therapy is given timely, 90% of the deaths can be prevented.[10]

Proper breast feeding and initiation of complementary feeding on 6th month provide protective factors that could help reduce various infections including diarrhea.[11] Mothers' basic knowledge about diarrhea depends on numerous factors such as educational status, prior experience of managing the disease and ethnicity.[12] Interventions to prevent diarrhea, including safe drinking-water, use of improved sanitation and handwashing with soap, can reduce diarrhea risk.[13] Diarrhea should be treated with oral rehydration solution (ORS). In addition, 10-14 days supplemental treatment course of dispersible zinc tablets shortens diarrhea duration and improves outcome.[2]

There were varying beliefs of natural as well as supernatural origin among the mothers about the types of diarrheas severity, causes and management, beneficial and harmful foods/fluids, efficacy of the advised modern health actions, and beliefs and barriers about preventing or managing diarrhea among children under five. Mothers can significantly reduce the potential of diarrheal disease occurrence by practicing simple preventive and management strategies.[14] Diarrheal disease remains a major public health threat for developing countries and is attributed to poor sanitation, unhygienic practice, and inadequate supply of purified drinking water.[15] Therefore, the aim of this study is to assess knowledge regarding management of diarrheal disease among mothers of under five children.

METHODS

Study design and setting

A quantitative descriptive cross-sectional study was conducted in pediatric OPD of Gandaki Medical College Teaching Hospital and Research Center (GMCTHRC) after obtaining ethical clearance from the Gandaki Medical College Institutional Review Committee (GMC-IRC) Ref. 106/080/081-S.

Inclusion and exclusion criteria

The mothers of under-five who were willing to participate and mothers who were available at the time of study were included in the study. The mothers who didn't give consent and those who were not available at the time of study were excluded from the study.

Sample size

A total of 70 mothers who have six months to five years children attending pediatric outpatient department of GMCTHRC were interviewed. Non-probability convenience sampling technique was used.

Based on the prevalence rate of 10% of sample size having good knowledge regarding management of diarrhea in Gujrat (Muniyangdi, population proportion with 95% confidence interval and 5 allowable errors, sample size for infinite population in quantitative approach is calculated using Cochran's equation.

Sample size(n)= z^2PQ/e^2

Where,

Z=1.96 at 95% significance level

P=prevalence of knowledge on diarrheal disease=0.1

q=1-p=1-0.1=0.9

e=allowable error (5%)=0.05

Hence, substituting formula-(1.96)2×(0.1)×(0.9)/(0.05)=138.

Adjusting the above sample size for a finite population.

Total children from 6 months to 5 years attending pediatric OPD of GMCTHRC obtained from OPD register in months=727

In 1 month=727/3=242, in 15 days=242/2=121

So, finite population (N)=121

So, here no=138

$$n = \frac{n_0}{1+\frac{n_0}{N}} = \frac{138}{1+\frac{138}{121}} = 64$$

Now estimating 10% as non-response rate, final sample size=n+n×10%=64+6.2=70.

Data collection

Data was collected within two weeks' period from 2081/3/26 to 2081/4/9. A pre-designed structured

dichotomous questionnaire was used to collect data on mothers' knowledge regarding management of diarrheal disease. A questionnaire/tool was prepared in English language and was then translated into Nepali language for study participants. The instrument was organized into two parts that is part I: Questionnaire related to demographic and personal data of respondents and part II: Questionnaire related to knowledge regarding management of diarrheal disease. It consists of 21 Dichotomous questions. Each correct answer was given a score of 1 mark for wrong answer 0. Answer key was prepared for scoring answers to the structured questionnaire. Level of knowledge was categorized into three levels according to: good: >70%, fair: 50 to 70% and poor: <50%.

Pretesting of the instrument was done among 10 % of sample size i.e. seven mothers meeting the inclusion criteria in Noble children and women hospital and trauma center Pvt. Ltd. Pokhara-17. Informed written consent was taken from each respondent before data collection. Data collection was done using structured interview schedule through face-to-face interview method. Validity of the instrument was maintained based on extensive review of literature on similar subject matter and seeking the opinion of the research advisor, subject's expert in the field of nursing.

Statistical analysis

After the data was reviewed and checked for completeness, consistency and accuracy, the statistical analysis was done by using SPSS version 16.0. Data analysis and interpretation were done based on objectives of the study. Descriptive statistics was applied which includes frequency, percentage, mean and standard deviation was used to interpret results. Inferential statistics method includes Chi-square test was done to determine the association between level of knowledge and selected variables.

Inferential statistical tests, such as the chi-square test of independence, were conducted to identify potential relationships between KAP levels and various demographics (e.g., age and gender) and professional factors (e.g., clinical experience and educational level). Statistical significance was defined as a p-value < 0.05, ensuring a robust interpretation of the findings. All analyses adhered to rigorous data-handling standards, and results were presented in detailed tabular formats for clarity and precision.

RESULTS

A total of 70 mothers who have children under five were interviewed. Out of 70, 58.6% were mothers who were older than 29 years. The mothers' mean age was 28.94 years. The maximum number of respondents (38.6%) were from the upper caste group. Most participants (82.9%) were following Hinduism, and 51.45% of participants were from urban residences. All the respondents participating in the study were literate (100%). 52.9% have completed a basic level of education, 25% could only read and write, and 21.4% have completed secondary-level education, as shown in Table 1.

All the respondents who participated in the study were employed (100%). Among them, the highest number of subjects (74.3%) were homemakers, while only 1.4% were employed with governmental service. Similarly, half of the respondents (50%) had 10,000-36,000 as their monthly family income. 54.3% had information from books, and most of respondents (61.4%) had a diarrhoeal history in their children, as presented in Table 2.

Table 2 shows most of the children (61.43%) were older than 28 months. The mean age of the children was 27.53 months. More than half of the children (61.4%) were male, while only 38.6% were female.

Table 3 shows that most of the participants (97.1%) responded correctly that diarrhoea is loose, watery stool passed more than 3 times a day. 70% of the respondents answered that contaminated food and water sources are the cause of diarrhoea in children under five. Similarly, 58.6% responded that excessive diarrhoea does not lead to constipation, and 61.4% of subjects answered that children suffering from diarrhoea should not stop breastfeeding. Furthermore, all the respondents agreed that handwashing before ORS preparation is necessary and ORS solution is one of the treatments for diarrhoea. However, only 41.4% showed half a sachet of ORS, and 2 litres of full water are required for the preparation of ORS. The majority of respondents (78.6%) reported that after using half a sachet, the other half of the sachet of ORS should not be stored for future use. Among 70 participants, 78.9% showed that once prepared, ORS cannot be used for 3 days. Similarly, most of the subjects (85.7%) showed that after each watery diarrhoea passed, ORS should be given. 60% of subjects answered that ORS does not prevent loss of appetite. Half of respondents (50%) showed that if a child starts vomiting during ORS feeding, we should immediately stop feeding ORS and breastfeed for 1 hour. Furthermore, 55.7% responded that zinc tablets are not given for diarrhoea treatment.

Three fourths of respondents (74.3%) answered that child diarrhoeal faeces should not be disposed of at convenient or open places. 87.1% responded that exclusive breastfeeding prevents diarrhoea. All the respondents agreed that handwashing practices before and after feeding are necessary for controlling and preventing diarrhoea. Similarly, 50% of subjects showed that continued bottle feeding doesn't prevent diarrhoea. Most of the participants (94.3%) answered that good hygiene behaviour and adequate breastfeeding prevent diarrhoea. The 58.6% answered that dehydration is the complication of diarrhoea. Table 4 illustrates the respondents' level of

knowledge regarding diarrhea management. 55.7% of respondents had good knowledge, one third (41.4%) had average knowledge whereas only 2.9% of the respondents had poor level of knowledge. Table 5 illustrates that there is no significant association between level of knowledge on management of diarrhea and demographic variables.

Table 1: Socio-demographic characteristics of the respondents, (n=70).

Characteristics	N	Percent (%)
Mothers age (in completed years)		
≤29	29	41.4
>29	41	58.6
Mean±SD=28.94±4.81, Min=20, Max=45		
Ethnicity		
Dalit	17	24.3
Disadvantages Janajatis	15	21.4
Disadvantages non-Dalit Terai caste group	1	1.4
Religious minorities	2	2.9
Relatively advantage Janjatis	8	11.4
Upper caste group	27	38.6
Religion		
Hinduism	58	82.9
Buddhism	5	7.1
Islam	4	5.7
Christianity	3	4.3
Place of residence		
Urban	36	51.4
Rural	34	48.6
Types of family		
Nuclear	55	78.6
Joint	15	21.4
Education status of mother		
Literate	70	100
Level of education of mother		
Only read and write	18	25
Basic level	37	52.9
Secondary level	15	21.4

Table 2: Socio-demographic characteristics of respondent, (n=70).

Characteristics	N	Percent (%)
Occupation of mother		
Employed	70	100
Employed		
Governmental service	1	1.4
Non-governmental service	7	10
Business	3	4.3
Farmer	7	10
Homemaker	52	74.3
Monthly income of family (in NPR)		
Less than 10,000	5	7.1
10,000-36,000	3.5	50
36,000-1,11,000	25	35
>1,11,000	5	7.1
Source of information		
Television	20	28.6
Books	38	54.3
Health care provider	12	17.1
History of diarrheal disease in children		
Yes	43	61.4
No	27	38.6

Continued.

Characteristics	N	Percent (%)
Number of children		
One	40	57.1
Two	24	34.3
Three	6	8.6

Table 3: Respondents response regarding knowledge of management diarrheal disease, n=70.

Statements	Yes, N (%)	No, N (%)
Diarrhea is loose watery stool passed more than 3 times a day	68 (97.1)	2(2.9)
Contaminated food and water sources are the cause of diarrhea in under five children	70 (100)	0
Low birth weight is the risk factor of diarrhea	24 (34.3)	46 (65.7)
Excessive cry and unable to suck breastfeeding are one of danger signs of diarrhea	49 (70)	21 (30)
Excessive diarrhea leads to constipation	29 (41.4)	41 (58.6)
If your child is suffering from diarrhea, you should stop breast feeding	27 (38.6)	43 (61.4)
ORS is one of the treatments of diarrhea	70 (100)	0
Handwashing before ORS preparation is necessary	70 (100)	0
Half sachet of ORS and 2 liters of full water is required for ORS	29 (41.4)	41 (58.6)
After using half sachet, half sachet ORS should store for future use	15 (21.4)	55 (78.6)
Once prepared ORS can be used for 3 days	19 (27.1)	51 (78.9)
After each watery diarrhea passed ORS should be given	60 (85.7)	10 (14.3)
ORS prevents loss of appetite	28 (40)	42 (60)
If child vomits during ORS feeding immediately stop feeding stop feeding ORS and breast feeding for 1 hour	35 (50)	35 (50)
Zinc tablet is given for treatment of diarrhea	31 (44.3)	39 (55.7)
Child diarrheal feces should dispose at convenient places or open area	18 (25.7)	52 (74.3)
Exclusive breastfeeding helps prevent diarrhea	61 (87.1)	9 (12.9)
Handwashing practices before and after feeding necessary for controlling, preventing diarrhea	70 (100)	0
Bottle feeding should continue to prevent diarrhea	35 (50)	35 (50)
Good hygiene behavior and adequate breastfeeding prevent diarrhea	66 (94.3)	4 (5.7)
Dehydration is the complications of diarrhea	41 (58.6)	29 (41.4)

Table 4: Respondents level of knowledge regarding management of diarrheal disease, n=70.

Level of knowledge	N	Percent (%)
Good knowledge (>75%)	39	55.7
Average knowledge (50 to 75%)	29	41.4
Poor Knowledge (<50%), Mean±SD=2.52±0.55; Min=1 Max=3	2	2.9

Table 5: Association between the level of knowledge and demographic variable and source of information, (n=70).

Variables	Level of knowledge, N (%)		χ^2	P value
	Good	Average		
Mothers age (in completed years)				
≤29	19 (48.7)	18 (58.1)	0.605	0.436
>29	20 (51.31)	12 (41.9)		
Level of education				
Below secondary	30 (76.9)	26 (83.2)	0.521	0.470
Up to secondary	9 (23.1)	5 (16.1)		
Residence				
Urban	22 (56.4)	14 (45.2)	0.875	0.350
Rural	17 (43.6)	17 (58.8)		
Family income (in NPR)				
≤36,000	9 (23.1)	9 (29.0)	0.321	0.571
>36,000	30 (76.9)	22 (71.0)		

Continued.

Variables	Level of knowledge, N (%)		χ2	P value
	Good	Average		
Source of information				
Books	28 (71.8)	22 (71.)	0.006	0.939
Others	11 (28.2)	9 (29.0)		
Previous history of diarrhea				
Yes	23 (59.0)	20 (64.5)	0.224	0.636
No	16 (41.0)	11 (37.9)		
Age of child (in completed month)				
≤28	26 (64.1)	20 (64.5)	0.001	0.971
>28	14 (35.9)	11 (35.5)		
Sex of child				
Male	23 (59)	20 (64.51)	0.301	0.583
Female	16 (41.0)	11 (35.5)		

*Chi square test significant (significance, p value ≤0.0), poor level of knowledge and average level of knowledge were merged one of the cells had less than 5 cells.

DISCUSSION

The findings were more than half of respondent (55.7%) had good knowledge and 2.9% had poor knowledge similar with study conducted by Garg et al in Nagaland, India which revealed that two third (65%) of respondents had good knowledge and 4% had poor knowledge regarding management of diarrheal disease.[16] Similarly, these findings are in contrast with the study conducted by Upashe et al in Bengaluru, India which revealed only 6.7% had adequate knowledge about diarrhea and 53.3% of subjects had inadequate knowledge regarding management of diarrhea.[17] This may be due to high illiteracy rate and different study areas.

Our study shows that maximum number of respondents (97.1%) had knowledge about definition of diarrhea and all the patients agreed that contaminated food and water sources are the cause of diarrhea in children under five. Similarly, 58.6% had knowledge that dehydration is the complications of diarrhea, which is similar to the study conducted by Abdulla, Mohammed (2021) which showed that most of the respondent (96.1%) had knowledge regarding diarrhea and half of the respondent (58.2%) had knowledge that dehydration is the complications of diarrheal disease.[18]

Out of total, 61.4% of mothers had knowledge that they should not stop breastfeeding if their children are suffering from diarrhea which is similar to the study conducted by Upashe et al which showed that 64% had knowledge about continuing breast-feeding during diarrhea.[17] Similarly, 58.6% had knowledge that half sachet of ORS and 2 liters of full water is required for ORS preparation, and most of the respondents (85.7%) knew regarding intake of ORS after each liquid diarrhea is passed. In contrast to the findings, study conducted by Garg et al revealed that most of respondents (88%) had knowledge regarding ORS preparation and few respondents (20.5%) had knowledge regarding intake of ORS after each liquid diarrhea passed.[16] This may be due to low literacy rate and different study settings.

The present study showed that 2.9% had poor, 41.4% had average and 55.7% of subjects had good level of knowledge which contrast to the study conducted in Madhuban, Sunsari, Nepal by Sanjeeb shah and Mausam Shrestha et al which showed only few (23.3%) had good knowledge, 40% had average knowledge and 36.7% of subjects had poor knowledge regarding management of diarrhea.[5] This may be due to differences in sample size and study area. The current study shows that there was no significant association between level of knowledge on management of diarrhea and demographic variables which is similar to the findings obtained in a study by Rana et al that shows no significant association between level of knowledge and the socio- demographic variables.[19]

Strengths and limitations

The study measures both descriptive (frequency, percentage, mean, SD) and inferential statistics (chi-square tests) that enhance the analytical depth. Furthermore, association of level of knowledge and multiple demographic factors were shown that allows a holistic assessment. However, the study was conducted in pediatric OPD of GMCTHRC which is limited to the mothers of children from 6 months to five years. Similarly, the sample size of the study was small, which cannot be used to generalize about the whole population.

CONCLUSION

More than half of the mothers had good knowledge regarding management of diarrheal disease. All the respondents were aware of ORS as a treatment for diarrhea and handwashing practices, but some mothers were unaware of zinc supplementation as part of diarrheal management. This highlights the need for targeted health education interventions focusing specifically on zinc supplementation in diarrheal management ensuring mothers are fully equipped to manage diarrhea effectively.

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