country(8-10); we found it to be 10%. The higher prevalence in the 3-5 years age group has been reported earlier also(9-10) and is probably due to poor availability of vitamin A in diet because of poverty and ignorance, coupled with impaired vitamin A metabolism because of the high incidence of diarrheal and respiratory diseases and worm infestations.

The prevalence of various manifestations of xerophthalmia far exceeded the prevalence criteria set by WHO for determining the public health significance of xerophthalmia(4), making it a significant public health problem in the area surveyed.

While 96% of xerophthalmic children were malnourished, 77% of all malnourished children had no apparent evidence of xerophthalmia. Thus, malnutrition is not always associated with xerophthalmia; perhaps repeated respiratory and intestinal infections and worm infestations aggravate or precipitate vitamin A deficiency when stores are marginal.

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Maternal Beliefs Regarding Diet During Acute Diarrhea

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The modern management of acute diarrheal illness emphasizes oral rehydration and early feedings(1). Such simple

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Received for publication: April 27, 1992;
Accepted: December 1, 1992

methods of management open the prospects of involving mothers in the care of child at home early at the onset of diarrhea. This is possible if mothers understand the significance of these problems and participate in their prevention and treatment. In order to achieve this goal, it is important to understand the prevalent beliefs regarding diet during diarrhea in the community. The present study was undertaken with the objective to find out the prevalent maternal beliefs regarding diet during acute diarrhea in children.

Material and Methods

We studied one of the field practice area of Maulana Azad Medical College, Mata Sundari Road Quarters, about one km away from our Medical College. The majority of the population belongs to lower caste and is engaged in occupation regarding skilled work. They are comparable with respect to socio-demographic features, health infrastructure and morbidity pattern. All houses have adequate Government/Civic facilities. Health care is mostly provided by Department of Preventive and Social Medicine, Maulana Azad Medical College, New Delhi during their field visits.

Results

A total of 254 houses out of 300 houses were surveyed for the present study. All locked houses, houses only for commercial purposes and houses without children below five years of age were excluded.

In 254 houses, there were 281 children below five years of age. Point prevalence in last one month was 16.01% (not counting the diarrhea reported at the time of cross sectional survey). A different prevalence of diarrhea in this study could be probably due to differences in the study methodology, nature of population and other geographical and socio-economic conditions of the community.

On enquiry about the household fluids given during diarrhea it was observed that lemon juice water (nimbu pani), sugar-salt solution, ORS packets were used by most of the families (23.28, 22.34 and 21.34 and 21.08% respectively). Fifty seven (11.98%) families used only plain water during diarrhea, 16 (3.34%) families did not use any fluid. Only 28.34% of the respondents opined to continue to feed normal diet as before, during diarrhea (inclusive of solid foods), whereas 45.27% of respondents shifted from normal to liquid diet. A total 16.53% respondents restricted few foods while 9.84% respondents opined to stop all food during diarrhea in children.

Majority (61.42%) of respondents preferred to feed their children as before when diarrhea had stopped while 12.20% respondents gave more food and 26.38% gave less food for 2-3 days during convalescence. Almost half (47.24%) of respondents observed no harm in continuation of breast feeding during diarrhea while few respondents either restricted (12.59%) or stopped (19.29%) breast feeding during diarrhea.

Analysis of diarrheal morbidity shows that children who continued to breast fed showed less diarrheal prevalence (18.33%) as compared where breast feeding was either stopped or restricted.

Discussion

The beliefs of mothers regarding feeding during diarrhea, are dependent on several factors: information passed on from generation to generation, advices given by the elders and past associations.

The widespread practice of restriction of food during and even after the subsidence of diarrhea is based on the advice mainly of elders at home and because parents feel that intensity of diarrhea decreases on food/fluid restriction. The knowledge-attitude-practice surveys, though limited in number, showed a pattern of reduced fluid/food intake and withholding of food (2-5).

As mentioned earlier, nimbu pani is commonly used as a home made fluid given during diarrheal illness, while Srinivasa(2) in Goa observed rice water (conjee fluid) as common home made fluids given during diarrhea. This is because of geographical variation in availability of food items. Advice regarding fluid and nourishing food during diarrhea will be only taken by the mother if it is culturally acceptable. Early starting of fluid therapy by HAF is the key for better management of diarrhea. Nimbu Pani, SSS, ORS which is very commonly used by the respondents, might supply the fluid to the child provided these preparations are hygienically prepared.

The popular belief is that food should be restricted or stopped. Nearly 72% of the respondents in the present study also changed the feeding pattern one way or the other. This is contrary to the guideline given by the World Health Organisation(1). The reason for advocating continuation of feeding is mainly nutritional because most of the children in developing countries are already malnourished and diarrhea further aggravates it. To prevent more severe malnutrition after diarrhea, it is important that mothers have to be educated that a child with diarrhea should get his normal diet to maintain his nutrition and the fear that food may not be digested will have to be dispelled.

The present study emphasizes the importance of assessment of present belief in the mothers regarding feeding habits during diarrhea. Knowledge of these beliefs will help in evolution of cultural or regional specific nutritional or educational programmes. An appropriate health education programme will have to be inroduced so that correct knowledge spread throughout the people without antagonism. This can be accomplished by discouraging harmful beliefs and encouraging useful beliefs.

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