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LAY BELIEFS ABOUT DIARRHOEAL DISEASES: THEIR ROLE IN HEALTH EDUCATION IN A DEVELOPING COUNTRY

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Abstract—This study examines the beliefs and understandings concerning diarrhoea among 2 groups of Zimbabwean women. Mothers with formal education are compared to those with less formal education. Differences and commonalities of beliefs are examined. The findings show that traditional explanations of an illness such as diarrhoea can inhibit health education campaigns against this disease which kills many children every year. Copyright © 1996 Elsevier Science Ltd

Key words—diarrhoeal disease, health education, Zimbabwe

INTRODUCTION

This research is a qualitative exploration into lay beliefs concerning diarrhoea and offers an assessment of the role of these beliefs in public health education programmes. Lay beliefs are constructed by people about areas in their lives about which they have no specialised knowledge. These beliefs are a collection of imagined sequences of events and systematic plans of actions pertaining to a particular subject, which explain how and why things occur. The function of a lay belief to the individual is to summarise and organise information by defining what is salient; reveal relationships between salient aspects; describe origin and cause; give some control over the future by suggesting behaviour and the resultant outcome of that behaviour [1, 2]. Lay beliefs are formed by an interaction between an individual's social environment and her/his internal cognitions. This paper focuses on the processes involved in the lay beliefs of urban Shona women which pertain to diarrhoeal diseases.

Diarrhoea is one of the most frequent childhood diseases. The current level of morbidity of diarrhoea in children under 5 years has been estimated to be 3.5 episodes per child per year [3, 4]. In less developed countries diarrhoea accounts for approximately 40% of all deaths of children under 5. The mortality rate is 6.6/1000 which implies the death of an estimated 4.5 million children per year [3]. In Zimbabwe, diarrhoeal diseases are second only to acute respiratory infections in responsibility for mortality of children under 5. There are an estimated 4.3 episodes per child per year and the attributed mortality rate is 4.2/1000 which represents 27% of all deaths in this age group [5]. These figures explain why so many preventative measures have been implemented in recent decades. The interventions which have been employed can be categorised as follows:

(1) improving environmental factors; for example, providing adequate water and sanitation facilities [6, 7]
(2) immunisation campaigns [8, 9]
(3) introducing behavioural changes. For example, the promotion of personal and domestic hygiene [10]; the promotion of food hygiene [7]; the promotion of breast feeding [8]; improving weaning practices and lactation [11] and promoting the palliative use of Oral Rehydration Treatment [ORT].

Despite the fact that each of these approaches has received considerable attention and that research has yielded a more comprehensive understanding of the aetiology, risk factors and pathogenesis of diarrhoeal diseases, the morbidity and mortality rates of diarrhoea remain very high. New approaches to the problem are to intensify efforts for training health care providers in diarrhoea case management and to implement broad health education campaigns among mothers with young children.

Research has shown that when health education intervention programmes include the investigation and utilisation of lay health beliefs then their efficacy is greatly improved [11]. As can be seen from the categories outlined above, the majority of interventions involve some form of behaviour modifi-

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cation. It is therefore surprising that very few of these intervention campaigns have included investigations of the lay health beliefs which exist within the target communities. Hence this research aims to contribute towards the understanding of lay health beliefs and their influence on both the treatment of diarrhoea and the education of the public about diarrhoea in Zimbabwe.

In Zimbabwe 2 health care systems coexist, the modern western and the local traditional. These health care systems are considered complimentary by many Shona people. Mutambirwa [12] gives a number of explanations for this duality within people's health seeking behaviour and beliefs: western medicine, often through indifference, has left traditional health beliefs unaltered. Traditional health care is holistic in its approach considering physical health as being affected by 2 main factors: the individual's physical environment and the environment created by the individual's religion and philosophy of life. Although western medicine is considered the supreme authority concerning physical aspects of health, it neglects spiritual aspects. Thus traditional medicine remains complementary in that it is needed to treat health problems associated with a person's mental and spiritual environments [13, 14].

A major dimension of traditional Shona views of illness concerns those caused by "bad airs". People are surrounded by environmental "air", which contains both good and bad elements. When there is a disequilibrium in the environmental "air", where the bad elements exceed the good elements, then the individual is said to be surrounded by "bad airs"—*mamhepo*. Illness is believed to be facilitated by these "bad airs" which lower an individual's resistance to disease. There are 3 environments which are thought to interact: these are the physical, social and spiritual environments. "Bad airs" originate from either the natural (physical) or unnatural (spiritual) environments. The former cause minor "normal" health problems. These are illnesses which affect only the body and result in minor, temporary changes in blood or body physiology, such as coughs, fevers and diarrhoea. The causes lie entirely in the physical environment, such as decaying matter, seasons or temperature changes. Treatment of these diseases is prescribed by respected, knowledgeable persons within the community and involves no delving into the spiritual environment [13, 14].

This study aims to examine the underlying beliefs about diarrhoeal disease and to place them within a cultural context which may inform health education programmes.

*The terms "educated" and "uneducated" relate exclusively and specifically to the criteria of this research project and do not imply any judgements of value of ability.

METHODS

This is an ethnographic study in which a group of educated mothers was compared and contrasted with a group of less educated mothers. Two data collection instruments were used. The first was that of formal focus group discussions and the second a structured open ended questionnaire. There were 2 focus group discussions, one with each study group, and the contents of these formed the basis for the construction of the questionnaire. After piloting the questionnaire, it was administered in the form of an interview.

Two focus groups were established; one of educated mothers and one of mothers who had little formal education. There was good agreement between the mothers' number of children, ages and years of education.

A structured open ended questionnaire was used as the other tool of data collection. It was formed from the information gathered from the focus group discussions and initially piloted upon 2 mothers from each group in order to obtain an optimal format and interview technique. The questionnaire consisted of sections relating to: demographic data; common childhood diseases; types of diarrhoea; perception of severity; symptoms of diarrhoea; causes of diarrhoea; treatments of diarrhoea and preventions of diarrhoea. The questionnaire used preliminary questions with the aim of accessing the content of mothers' lay beliefs and a series of prompts aimed at accessing the reasoning processes behind mothers' beliefs. The questionnaire was administered to mothers from each group and took the form of an interview of approximately one hour in duration. The information was gathered in Shona and was recorded in English.

Subjects

Subjects in the study were chosen according to certain criteria and were a convenience sample. The criteria for all subjects were as follows: they were mothers of 3 or more children, the youngest of which was 5 years or under, and they had been resident in an urban area for 2 or more years.

The distinguishing criterion of the 2 groups was level of educational achievement. Group One had all successfully completed their education to the level of the Ordinary Level Certificate ('O' Level Certificate) and had one post 'O' Level qualification, such as a diploma or certificate. Group Two had left school before completing their Ordinary Level Certificate of Education.*

There were 11 subjects who participated in the 2 focus group discussions. The subjects from both groups were recruited by word of mouth. The 6 subjects from Group One came from various places of employment and occupations. Four of the 5 subjects from Group Two were domestic workers and the other was not currently in commercial employ-

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