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ORIGINAL ARTICLE

EFFECT OF EDUCATIONAL ACTIVITY ON HEALTH PRACTICES OF UNDERCLASS V SCHOOL CHILDREN

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ABSTRACT: A cross sectional and observational study was done to find out existing level of knowledge, attitude and practice of different types of unhealthy habits among the school children. Total 300 students (Classed I to V) were included in this study. Chi square test, Z test and t test were applied to find out magnitude of knowledge, attitude and practices of unhealthy habits. A declining trend of knowledge, attitude and practice scores were seen in the study group and inclining trend was noted in the control group. Thus, the study carried out showed that sustained action is necessary to affect behavior change.

KEYWORDS: Knowledge, Attitude, Practice, Unhealthy habits, School children.

INTRODUCTION: Hygiene is a set of practices performed for the preservation of health. Health is the characteristic of life that enables a person to live longer. According to World Health Organization "Health is a state of complete physical, mental, spiritual and social wellbeing and not merely absence of disease". The word hygiene comes from the French hygiene "good for the health, healthy".[1] Hygiene practices are employed as preventive measures to reduce the incidence and spreading of diseases.[2]

The most affected are the populations in developing countries, living in extreme conditions of poverty. Providing access to sufficient quantities of safe water, the provision of facilities for sanitary disposal of excreta and introducing sound hygiene behaviors are capital importance to reduce the burden of disease caused by these risk factors.[3]

Micronutrient malnutrition is a serious threat to the health and productivity of more than two billion people worldwide.[4] 1/3rd of the world population are at risk of health and development consequences of vit-A, iron and iodine deficiencies. (Darton Hill 1998).[5]

Personal hygiene involves those practices performed by an individual to care for one's bodily health and wellbeing, through cleanliness.

School sanitation and hygiene education is an essential component of health education, which includes provision of toilet infrastructure and hand washing facilities in schools and hygiene education, to promote behavioral change amongst children. School sanitation and hygiene education recognizes the role of children as the best change agents in absorbing and popularizing new ideas and concepts of sanitation not only in school but in their families and neighborhood. So we proposed to do present study to find out the existing level of knowledge, attitude and practice of different types of unhealthy habits among the school children in urban area of Kishanganj.

MATERIALS AND METHODS:

STUDY DESIGN: Observational and cross sectional study.

STUDY PERIOD: May 2014 – May 2015, data was collected in a predesigned and pretested and structured proform.

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STUDY AREA: Saraswati Vidya Mandir situated in urban area of Kishanganj.

STUDY POPULATION: Total 575 students, 325 boys and 250 girls, out of which 300 students (Class I to V) were considered in this study.

SAMPLE SIZE: Sample size was calculated by the formula 4pq/L2, where p=proportional, q=1-p, L=allowable error, considered as 15% of value p. Sample size =100, multiply by 2. Final sample size approx 200.

SAMPLING DESIGN: Stratified random sampling technique was used in this study.

STUDY TOOLS: a) socio - demographic and economic information of the students. b) Pre designed and pre tested questionnaire to record knowledge, attitude and practice of the students regarding personal hygiene practices and food habits. c) Pre designed and pre tested course content with charts and posters to teach personal hygiene to the students. d) Torch to examine eyes, ears and throat. e) Stethoscope to examine chest in suspected acute respiratory infection. f) Snellens chart to record visual acquity. g) Colourful charts and posters to teach good personal hygiene practices. h) Soap and water for demonstrating proper hand washing. i) Tooth brush and tooth paste for demonstrating correct brushing technique.

PROCEDURE FOR DATA COLLECTION: Recording of socio demographic information of the students with the help of parents after informed consent was obtained. Their personal hygiene related knowledge, attitude and practice were tested by prepared questionnaire with check list. Student's knowledge, attitude and practice of personal hygiene was corroborated by observation made during school hours and preschool hours. Class teachers were given the copy of teaching content and materials after full explanation. They were requested to take lectures classes throughout the 6month period. They were also requested to demonstrate good personal hygiene practices to their students. This was complimented with interpersonal communication with each student during health checkups.

After 6 months of the study, retesting of knowledge, attitude and practice regarding personal hygiene was done using same checklists and questionnaire.

When the study was started, control group was selected and those students did not entertained to attain any health education lectures or demonstration classes.

DATA ANALYSIS PLAN: Data was entered in Microsoft Excel and analysis done by Statistical Package for Social Scientists (SPSS) version 10. Chi square test and T test applied to find out the magnitude of knowledge, attitude and practices of unhealthy habits and p value <0.05 was considered significant.

RESULTS AND ANALYSIS: In the present study male were more in number than female students. In the study group male were 60% and females 40% and in control group 67.5% and 32.5% respectively. There was significant difference between the study group and the control group regarding sex of the study population ($p<0.05$).

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In the present study there was no significant difference between the study group and the control group regarding age of the study population. Majority of study group 35% and in control group were from 7 to 8 years age group in the study population (p>0. 05).

In the present study other occupation were more in number. Majority of the study group among others were 50% and BSF & business were 20% and 30% respectively, and in control group 65%, 20% and 15% respectively.

In the present study of distribution of maternal literacy, in study group majority i.e., 25% were educated up to higher secondary and only 10% were graduates. In control group majority 22. 5% were preschool and 17.5% belonged to no literacy group. There was significant difference between study group and control group regarding maternal literacy among study population. (p<0. 05)

Muslims were higher in study group 40% and Hindu, Sikh and Jain were 35%, 15% and 10% respectively. In control group also Muslims were on higher side 40% and Hindu, Sikh and Jains were 35%, 15% and 10% respectively. There was significant difference between study group and control group regarding religion among study population (p<0. 05).

In the present study there was no significant difference between study group and control group regarding knowledge score, attitude score and practice score obtained before study. Most of the students got average score.

DISCUSSION: Survey among school children in India showed that about half of clinical ailments found were due to unsanitary conditions and lack of personal hygiene.

In the present study, most of the students of both groups were males 60% in study group and 67.5% in control group and females were 40% in study group and 32.5% in control group. In Bihar by SWASTHH (School, water and sanitation towards health and hygiene) and Government of India in 2013 in Munger at Srinanda high school - most of the students were male- 48.9% and 35% in study group and control group respectively and female 35% and 29. 7% in study group and control group respectively - which were comparable.[6]

Most of the students belonged to 7-8 years age group in study group and 9-10 years age group in the control group (35% in the study group and 32. 5% in the control group)- which were not comparable. Mean age of the students were not comparable in both study group and control group. Most of the students belonged to 7-8 years age group in both group – 38. 5% in study group and 39. 5% in control group. Data collected from IEC (Information, Education and Communication) and UIC (Unesco Institute for children) – a NGO worked for the school children in 2011.[7]

Most of the students came from other occupational ground, there was significant difference in study group (60%) and control group (65%)–which were not comparable. F. Khan et al (2010) - found that there was no significant difference between the study and control group in the study population - which was mostly labour class – 38.8% and 44.5% - in study and control group respectively.[8]

Most of the students had maternal education of high school comparative to very low of graduate level, most of the mothers were housewives - there was significant difference in the study and control group- comparable. F. Khan et al (2010) – study research on the students on the basis of maternal literacy were comparable in both groups – 61.7% in urban area of Bihar and 15.9% in rural areas of Bihar. So the maternal literacy of the study population was quite significantly comparable.[8]

In Kishanganj (Bihar), Muslims were 40% and Hindus were 35% in the control group. So most of the study population was Muslims which was significant. There was maximum Muslim based students - 88.9% were Muslims and other classes were 70.5% in the year 2006.[9]

There was no significant difference between study group and control group regarding knowledge score, attitude score and practise score obtained before and after study. The findings showed major deficiency in health related knowledge. Most of the students got average scores. Hilleboe in 1965 conducted nationwide school health education study in USA in 3 phases–Phase I done to assess knowledge of current health status of school education programme, Phase II–included survey of health knowledge and last Phase III–development of health knowledge. The findings of this study was 54% in phase I, 53% in PHASE II and 50% in last phase III.[10]

CONCLUSION: The present study proved that sustained action should be taken to affect behaviour change. The study and control group were statistically similar in most respects of the socio – demographic – economic parameters except religion.

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