

“A Study To Assess The Effectiveness Of Child To Child Programme On Knowledge And Expressed Practice Regarding Ways To Improve Physical And Mental Health Among School Children At Selected School, Daman”

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Abstract

Background: Health is a very important aspect for every individual for living in this earth. Adolescence is a period of transition between children and adults. And in this period, adolescents experience many changes in their body and minds. Child-to-child programme is an educational process that links children's learning with taking action to promote health and wellbeing. Physical wellbeing direct results of lifestyle choices and behavior about sleep, hygiene, diet, physical activity and relaxation that achieve desire functioning. Mental health includes our emotional, psychological and social wellbeing.

Aim: The aim of the study was to evaluate the effectiveness of a child-to-child programme on knowledge and expressed practice regarding ways to improve physical and mental health among school children.

Methodology: A Quasi-experimental one group pretest posttest design was adopted for this study. 10 change agents and 60 school children were selected by using simple random sampling technique (lottery method) from Government High School (English Medium), Nani Daman.

Result: The results of the study showed that the mean pretest knowledge score was 9.8833 and the mean posttest knowledge score was 15.366. The calculated 't' value of knowledge was 14.63 at $df=59$ and the table value was 1.671 at $p<0.05$ level of significance. The mean pretest expressed practice score was 37.93 and mean of the post test score was 55.316. The calculated 't' value of expressed practice was 15.49 at $df=59$ and table value was 1.671 at $p<0.05$ level. The chi square value showed that, there was a significant association between gender in knowledge and type of family in expressed practice at $p<0.05$ level of significance.

Conclusion: Thus, it was significantly proved that the child-to-child programme was effective for improving the knowledge score and expressed practice among school children.

Key Words: Child-to-child programme, knowledge, expressed practice, school children.

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I. Introduction

Health is a very important aspect for every individual to live on this earth. In, our society, health is not only an issue for doctors, nurses, social services and hospitals, it is also an issue of social justice. In ancient times, health was defined as “The absence of disease.” No one has the same viewpoint on the aspect of health. The ancient Indians and Greeks considered health as normal body equilibrium and disease as a disturbance in body equilibrium. Every person is free to live by his or her own way. But sometimes people adopt many irregular ways of living life because they do not understand the value of health until it is lost. As per the advancement of technology, people have come to know that health is a fundamental human right and is essential for the satisfaction of basic human needs and for the improvement of life, that is why it is a worldwide universal goal.¹

Adolescence is a stage of life characterized by health, growth and developmental needs, as well as fundamental rights. This is also a time to develop knowledge and skills, learn to manage emotions and relationships, and acquire traits and abilities that are important for enjoying the adolescent life and assuming an adult's role. Neuronal development also occurs during the adolescent's phase. Hormonal and neuro developmental changes during adolescence are associated with psychosocial and emotional changes and increasing cognitive and intellectual capacities.²

The Child-to-child concept was first developed in 1978 by Dr. David Morley and Dr. Hugh Hawes (Institute of Education) to commemorate the forthcoming International Year of the Child (1979). The child-to-child trust was established as an organization in 1987. Child-to-child programme helps in leading global

agencies in a number of practical approaches that enable children to play a meaningful role in their own lives and in communities for improving their overall health. The principle of the child-to-child programme were respecting children’s views and voices to enable them to grow into more responsible adults. Furthermore, it facilitates children’s understanding of developmental issues and why healthy behaviors are important, recognizes children’s capacities to change agents, who require the facilitative support but not the dominance of adults. This child-to-child vision of a world where children are empowered to participate in the realization of their rights.³

Child-to-child is an educational process that links children’s learning with taking action for promote the health, wellbeing and development of themselves, their families and their communities. These Child-to-child Programme aims to play a central role in fostering education, promoting health, and driving community development across a global network spanning over 70 countries. In order to strengthen the international network, resource groups based in India, Kenya, Lebanon, London (UK) and Pakistan have come to contribute their magnetic expertise and experience of capacity building in training, materials development, research and advocacy. This child-to-child is a right based approach to children’s participation in health promotion and development. Through participating in child-to-child activities the personal, physical, social, emotional, moral and intellectual development of children is enhanced. The convention’s guiding principles of inclusion, nondiscrimination and being in the best interests of the child underpin the child-to-child approach.⁴

Child-to-child Programme is based on the concept that children in schools and family members need to be considered as partners in spreading health messages into the community as well as benefiting from them. The group of children can be selected based on their formal or non-formal system of education or any group that is easy to assemble and feasible to follow up with. In this programme, the children are educated on simple but important health topics like environmental hygiene, prevention, treatment, first aid, anemia, personal hygiene, growth monitoring etc. In this programme the activities are made interesting and lively by using different modalities of education like demonstration, role play, song, pictures, crafts etc. After that, each child is asked to spread the health message. The least that is expected from these children to spread health messages to their siblings, parents and neighbors and then ultimately the messages spread to the community.⁵

Ha Noi, Ho Chi Minh City, 2023 -UNICEF is calling for enhanced mental health strategies to support the young generation in Vietnam as part of World Children’s Day. The findings of the latest National Adolescent Mental Health Survey highlighted a concerning reality: adolescents are struggling with mental health challenges, lacking the essential coping skills that support to their overall wellbeing. The survey revealed that one in five adolescents faces a mental health issue and with only 8.4 percent of them are able to assess the necessary support services or counselling for emotional and behavioral challenges. Moreover, only 5.1 percent of parents recognized their adolescence needed help with emotional and behavioral problem.⁶

According to World Health Organization global status report on physical activity in 2022, revealed that regular physical activity promotes both mental and physical health in people of all ages. Yet, today more than 80% of adolescents and 27% of adults do not meet the WHO’s recommended levels of physical activity. This affects not only individuals over their life course, but also places a financial burden on health services and society as a whole.⁷

A quasi- experimental study was conducted to assess the effectiveness of a child-to-child approach on knowledge and practices of personal hygiene among children in selected schools in Gujju Khera in the Patiala district of Punjab. The design of the study was two experimental groups: a pre-test and post-test group. The sample size was 90 students aged 10-12 years. These were selected by using a purposive, non-probability sampling technique. There were 30 samples from each group in the experimental group, group 1 (child-to-child approach) and group 2 (planned teaching) and 30 samples were assigned in control group. The data was collected through 44 structured knowledge questionnaires on different topics of personal hygiene and its importance. 3 subsets of a structured observational checklist was used to determine the correct tooth brushing procedure, hand washing techniques and practice regarding personal hygiene. The split- half method was used to measure the reliability of the knowledge scores and it was, $r=0.7$ and Inter-rater reliability was used to assess observational checklist and it was found $r=0.80$. The results of the study showed that posttest mean knowledge scores of experimental groups one (child-to-child approach) (33.93 ± 3.78) and the Group two (planned teaching), (35.75 ± 4.32) were higher than the control group of mean knowledge scores (21.70 ± 3.43). Therefore, the child-to-child approach was effective in improving personal hygiene in school children.⁸

A quasi-experimental study was conducted to evaluate the effectiveness of a child-to-child programme against dengue fever in terms of knowledge and expressed practice among school going children in Trichy. Sixty samples were selected from seven grade students by using a convince sampling technique. The researcher used a structured knowledge questionnaire and an expressed practice checklist for collect the data. The change agents were trained to initiate a child-to-child programme. After three days of training, a post test was conducted. On the fifteenth day, the student was allotted to the change agent for the initiation of programme. Each facilitator had five students in each group. Fourteen days later, a posttest was conducted. The results

showed that the mean posttest knowledge was 19.53 and expressed practice was 12.50 in experimental group whereas, in the control group the mean posttest knowledge was 13.36 and mean of the posttest expressed practice was 9.60. Hence, the study concluded that the Child -to- child programme worked well in the experimental group.⁹

A randomized controlled trial was conducted to examine the effects of a school-based physical activity intervention on adolescent mental health in Bangladesh. The sample consisted of 40 students in grades 8 and 9 from each school who participated in the experiment (n=160 per group). The intervention period for data collection was a 12-week physical activity program that included multiple components (e.g., supervised circuits, lunch exercise sports, health education, infographics), while the control group had not received any intervention. Participants completed baseline and post intervention surveys to assess depressive symptoms. These depressive symptoms were measured by the Center of Epidemiologic studies Depression Scale. The result showed that the intervention group's depressive symptoms decreased in the experimental group. Therefore, the study concluded that, a school based multicomponent physical activity intervention was effective in improving mental health indicators in adolescents.¹⁰

Objectives

1. To assess the pretest level of knowledge regarding the child-to-child programme on ways to improve physical and mental health among selected school children.
2. To assess the pretest level of expressed practices regarding the child-to-child programme on ways to improve physical and mental health among selected school children.
3. To assess the effectiveness of a child-to-child programme on knowledge regarding ways to improve physical and mental health.
4. To assess the effectiveness of a child-to-child programme on expressed practice regarding ways to improve physical and mental health.
5. To find out the correlation between the knowledge and expressed practices of the child-to-child programme on ways to improve physical and mental health among selected school children.
6. To find out the association between the pretest knowledge score of the child-to-child programme on ways to improve physical and mental health among school children with selected demographic variables.
7. To find out the association between the pretest expressed practices score of the child-to-child programme on ways to improve physical and mental health among school children with selected demographic variables.

Hypotheses

The Hypothesis was tested at the 0.05 level of significance.

H₁: There will be a significant mean difference between the pretest and posttest knowledge score regarding the child-to-child programme on ways to improve physical and mental health.

H₂: There will be a significant mean difference between the pretest and posttest expressed practices score regarding the child-to-child programme on ways to improve physical and mental health among school children.

H₃: There will be a significant correlation between knowledge and expressed practice score of ways to improve physical and mental health among school children.

H₄: There will be a significant association between the pretest knowledge score regarding ways to improve physical and mental health among school children with selected socio demographic variables.

H₅: There will be a significant association between the pretest expressed practices score regarding ways to improve physical and mental health among school children with selected socio demographic variables.

Delimitation

- The sample size is limited to 60 school children.
- The study is limited to only 9th standard students.
- The study is focuses on only knowledge and expressed practice

II. Material And Methods

Research approach: quantitative evaluative research approach

Research design: quasi experimental one group pre-test post-test design.

Setting of the study: a pilot study was conducted at the government higher secondary school (english medium), damanwada, daman. A research study was conducted at government high school, nani daman (english medium), daman.

Population: in the present study population was school children.

Target population: in the present study, the target population was based on all school children studying in schools of daman.

Accessible population: school children who were studying in the 9th standard in government high schools (english medium) nani daman.

Sample: in the present study the sample were school children who were selected from the age group of 13 to 16 years, studying in the school of daman.

Sample size: the sample size was 60 school children of 9th standard, from a selected school, daman.

Sampling technique: simple random sampling technique.

Sampling Criteria

Sampling criteria involves selecting cases that meet some predetermined criterion of importance. The criteria for sample selection are mainly depicted under two headings, which include the inclusion and exclusion criteria.

Inclusion Criteria

- Students who were studying in 9th standard.
- Students who read, understood and wrote English.
- Students who were available at the time of data collection.
- Students whose age group was 13 to 16 years.

Exclusion Criteria

- Students who were not willing to participate in this study.
- Students who were absent on that day.

Description Of The Tool

The tool used for the study was seven socio demographic variables, 20 structured knowledge questionnaires and 16 questionnaires of expressed practice on a five-point rating scale regarding ways to improve physical and mental health.

Section A: Socio Demographic Variables

Section B: Self structured knowledge questionnaire

Section C: Expressed practice rating scale

Section A: Socio demographic Variables

The socio demographic variables consisted total of seven items based on the background data of the participants. It included:

- Age
- Gender
- Type of Family
- Occupation of Father
- Occupation of mother
- Place of living
- Sources of information regarding ways to improve physical and mental health

Preparation of lesson plan

The preparation of a lesson plan regarding ways to improve physical and mental health was based on a review of the literature, discussion with the guide and co- guide and suggestion from the investigator's own experience.

Section- B: Structured Knowledge Questionnaire

It consists of following:

A structured knowledge questionnaire in the form of 20 multiple choice questions which was constructed for the students on ways to improve physical and mental health. A knowledge questionnaire score of '1' was allotted for each correct answer and score of '0' was allotted for each incorrect answer. The total maximum and minimum score were 20 and 0, respectively.

Table no :1.1 The score interpretation for the level of knowledge

Score	Percentage	Interpretation
≤ 10 marks	0%-50%	Inadequate knowledge
11-15 marks	51%-75%	Moderately adequate knowledge
16-20 marks	76%-100%	Adequate knowledge

Section-C: Expressed Practice Rating Scale

It consisted of 16 statements to assess the expressed practice of ways to improve physical and mental health among school children. The student was requested to give responses based on the frequency of experiencing a particular expressed practice against five options given namely:

- Never- score 1
- Often-score 2
- Sometimes- score 3
- Rarely- score 4
- Always-score 5

Table no :1.2 The score interpretation for the level of expressed practice

Sr. No	Score	Interpretation
1.	1-26	Poor expressed practice
2.	27-53	Moderate expressed practice
3.	54-80	Good expressed practice

Section-I: Description Of Socio Demographic Variables Of Participants Based On Frequency And Percentage

Socio demographic variables, which consist of 7 items were used to collect the sample characteristics such as age, gender, type of family, occupation of father, occupation of mother, place of living and sources of information regarding ways to improve physical and mental health.

Table No: 1.3 Description of socio demographic variables of participants based on frequency and percentage (n=60)

SR.NO.	SOCIO DEMOGRAPHIC VARIABLE	FREQUENCY	PERCENTAGE
1	Age in year		
	a)13-14 years	33	55%
	b)15-16 years	27	45%
2	Gender		
	a) Male	26	43.33%
	b) Female	34	56.67%
3	Type of family		
	a)Nuclearfamily	39	65%
	b) Jointfamily	18	30%
	c) Extended family	3	5%
	d)Single parent	0	0%
4	Occupation of Father		
	a) Government employee	1	1.67%
	b) Private employee	39	65%
	c)Business	11	18.33%
	d)Farmer	1	1.67%
	e) Daily wages	5	8.33%
	f) Unemployed	3	5%
5	Occupation of Mother		
	a) Government employee	0	0%
	b) Private employee	26	43.33%
	c)Business	0	0%
	d)Farmer	0	0%
	e) Daily wages	2	3.33%
	f) Homemaker	32	53.34%
6	Place of living		
	a) Rural area	18	30%
	b) Urban area	36	60%
	c) Semi Urban area	6	10%
7.	Sources of information regarding ways to improve physical and mental health		
	a) Mass media	26	43.33%
	b)Neighborhood	1	1.67%
	c)Health personnel	6	10%
	d) Any other attend special class, conference or seminar	1	1.67%
	e) Nil	26	43.33%

Above table showed the distribution of participants with their socio demographic variables.

Section-Ii: Description Of The Significant Mean Difference Between Pretest And Posttest Knowledge Score Regarding The Child-To-Child Programme On Ways To Improve Physical And Mental Health Among School Children.

Table No: 2.1:Description of frequency and percentage distribution of pretest and posttest level of knowledge
n=60

Level of Knowledge	Score	Pre-Test		Post Test	
		Frequency	Percentage	Frequency	Percentage
Inadequate Knowledge (0-50%)	0-10	43	71.67%	0	0%
Moderate Knowledge (51-75%)	11-15	17	28.33%	20	33.33%
Adequate knowledge (76-100%)	16-20	0	0%	40	66.67%

Table 2.1 depicted that in the pretest 43 (71.67%) of school children had inadequate knowledge on ways to improve physical and mental health, whereas in the posttest it was 0 (0%), 17 (28.33%) were with moderate knowledge in the pretest and in the posttest, it was increased to 20 (33.33%) and 0% school children had adequate knowledge in pretest, whereas in the posttest knowledge had increased to 40 (66.67%).

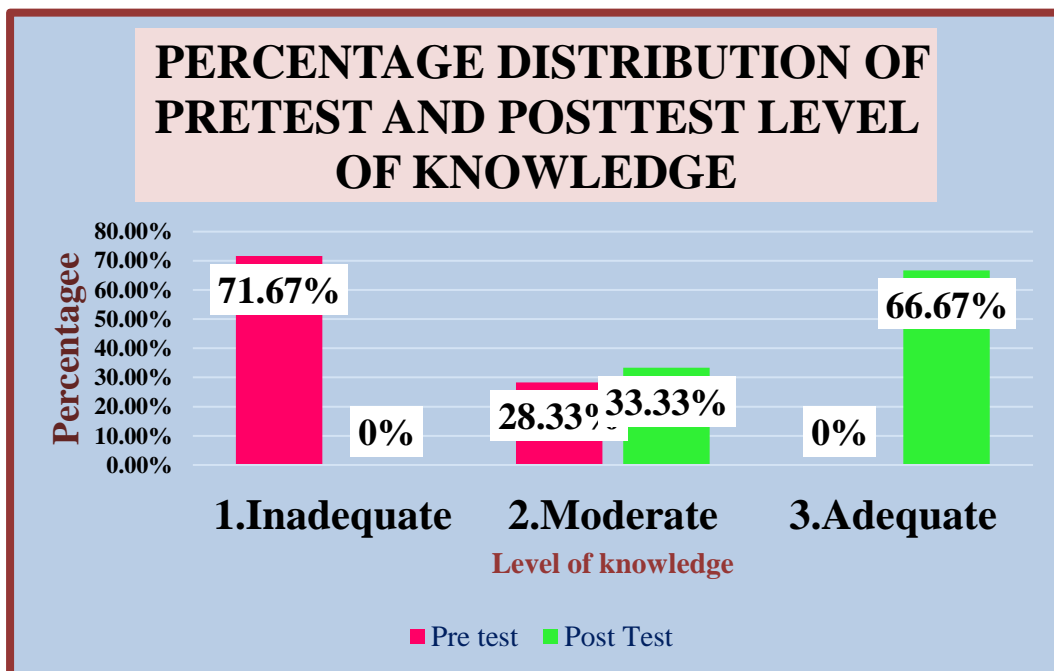


Table No: 2.2 Mean difference of pretest knowledge score and posttest knowledge score
n=60

Knowledge	Maximum score	Obtained score	Mean score	Mean %	Mean Difference	Mean Percentage (%) gain
Pre test	20*60=1200	593	9.8833	49.42%	5.4833	27.41%
Post Test	20*60=1200	922	15.366	76.83%		

Table 2.2 showed that the maximum knowledge score was 1200, the pretest obtained knowledge score was 593 and the mean of pretest knowledge score was 9.8833 with a mean percentage of 49.42% and the posttest obtained knowledge score was 922 and the mean of the posttest knowledge score was 15.366 with a mean percentage of 76.83%. The mean difference between the pretest knowledge score and the posttest knowledge score was 5.4833 and the mean percentage gain between pretest knowledge and posttest knowledge

was 27.41%. Hence, mean posttest knowledge scores were significantly higher than the pretest knowledge score.

Section-iii: Description Of The Significant Mean Difference Between The Pretest And Posttest Expressed Practice Score Regarding The Child-To-Child Programme On Ways To Improve Physical And Mental Health Among School Children.

Table No: 3.1 Description of frequency and percentage distribution of pretest and posttest level of expressed practice
n=60

Level of Expressed Practice	Score	Pre-Test		Post Test	
		Frequency	Percentage	Frequency	Percentage
Poor Expressed Practice	1-26	13	21.67%	0	0%
Moderate Expressed Practice	27-53	46	76.66%	10	16.67%
Good Expressed Practice	54-80	1	1.67%	50	83.33%

The table 3.1 depicted that, in pretest 13 (21.67%) of school children had poor expressed practice on ways to improve physical and mental health, whereas in posttest it was 0 (0%), 46 (76.66%) had a moderate expressed practice in pretest and in posttest it was 10 (16.67%) and 1(1%)school children had good expressed practice in pretest, whereas in posttest it was increased to 50 (83.33%).

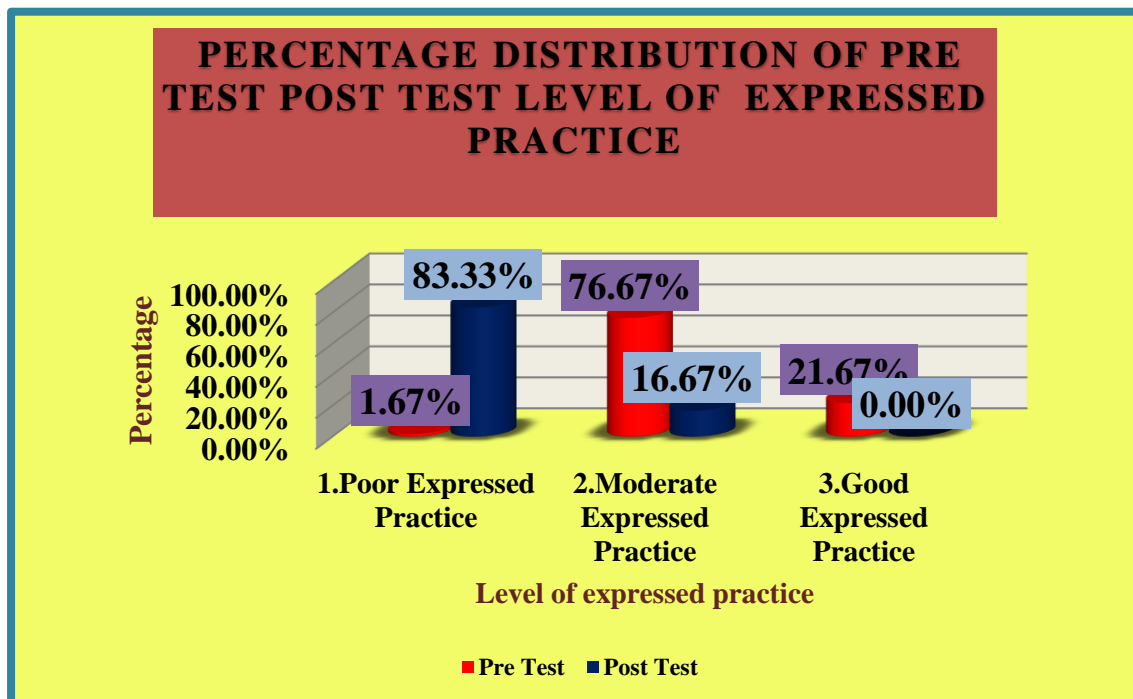


Table No: 3.2 Mean difference of pretest expressed practice score and posttest expressed practice score
n=60

Expressed Practice	Maximum score	Obtained score	Mean score	Mean %	Mean Difference	Mean Percentage (%) gain
Pre test	80*60=4800	2276	37.933	47.416%	17.383	21.729
Post Test	80*60=4800	3319	55.316	69.145%		

Table 3.2 showed that the maximum expressed practice score was 4800, the pretest obtained expressed practice score was 2276 and the mean of pretest expressed practice score was 37.933 with a mean percentage of

47.416 % and the posttest obtained expressed practice score was 3319 and the mean of the posttest expressed practice score was 55.316 with a mean percentage of 69.145%. The mean difference between the pretest expressed practice score and the posttest expressed practice score was 17.383 and the mean percentage gain between the pretest expressed practice and posttest expressed practice was 21.729%. Hence, the mean posttest expressed practice scores were significantly higher than the pretest expressed practice score.

Section-iv: Effectiveness Of A Child-To-Child Programme On Ways To Improve Physical And Mental Health On Knowledge And Expressed Practice Among School Children, Daman

Table No: 4.1 Mean, Mean difference, Standard deviation, standard error and paired ‘t’ test of pretest and posttest knowledge score regarding ways to improve physical and mental health among School children.

n=60

Knowledge	Mean	Mean Difference	SD	SE	Calculate value of ‘t’	Table Value of ‘t’	Inference
Pre-Test	9.8833	5.4833	2.82	0.3644	14.6344	1.671	S
Post Test	15.366		2.57	0.3318			

Note: S – Statistically significant $t > 1.671$ at the 0.05 level.

Above table 4.1 showed that the mean pretest level of knowledge regarding ways to improve physical and mental health among school children was 9.8833, which was significantly improved to 15.366 in the posttest with a mean difference of 5.4833. The standard deviation of the pretest level of knowledge regarding child-to-child programme on ways to improve physical and mental health was 2.82 and the posttest was 2.57. The standard error of pretest level of knowledge was 0.3644 and the posttest knowledge score was 0.3318. The calculated value of t was 14.6344, which was greater than the table value of $t=1.671$ at the level of $p < 0.05$.

Hence, the child-to-child programme on knowledge regarding ways to improve physical and mental health among the school children was effective to improve the knowledge regarding ways to improve physical and mental health among school children.

Table No: 4.2 Mean, Mean difference, standard deviation, standard error and paired ‘t’ test of pretest and posttest knowledge score regarding ways to improve physical and mental health among school children, Daman

n=60

Expressed Practices	Mean	Mean Difference	SD	SE	Calculate value of ‘t’	Table Value of ‘t’	DF	Inference
Pre-Test	37.93	17.383	9.090	1.173	15.49	1.671	59	S
Post Test	55.316		5.95	0.768				

Note: S -Statistically significant $t > 1.671$ at the 0.05 level.

The above table 4.4.2 showed that the mean pretest level of expressed practice regarding ways to improve physical and mental health among school children was 37.933, which was significantly improved to 55.316 in the posttest with a mean difference of 17.383. The standard deviation of the pretest level of expressed practice regarding the child-to-child programme on ways to improve physical and mental health was 9.0906 and the posttest was 5.9560. The standard error of the pretest level of expressed practice was 1.1736 and posttest was 0.7689. The calculated value of t was 15.49 which is greater than the table value of $t=1.671$ at the level of $p < 0.05$.

Hence, the child-to-child programme on expressed practice regarding ways to improve physical and mental health among the school children was effective to improve the expressed practice regarding ways to improve physical and mental health among school children.

III. Findings Of The Study

Findings of the pilot study

The pilot study was done on two change agents and 6 school children who were studying in Government Higher Secondary School (English Medium), Damanwada. The pilot study was conducted from 28/08/2023 to 11/09/2023.

For the statistical analysis of change agent’s reliability of knowledge was 0.9045 and the expressed practice was 0.85. For the group of student’s reliability of knowledge was 0.902 and for expressed practice it

was 0.9514. The reliability of the knowledge and expressed practice rating scale was analyzed by using the Karl Pearson Correlation Coefficient formula with test and retest method.

The final research Study

The final study was conducted from 12/10/2023 to 4/11/2023. Samples were from Government high school (English medium), Nani Daman. The study was analyzed by using descriptive and inferential statistics.

The results of the study were as follows:

- In the present study 33(55%) students were in the age group 13-14 years and 27(45%) students were in the age group of 15-16 years.
- With regard to gender the majority of 34(56.67%) school children were female and 26(43.33%) school children were male.
- In the present study the majority of 39(65%) school children belongs to the nuclear family.
- With regards to the occupation of father the majority of 39(65%) school children father occupation were private employees.
- In the present study, the majority 32(53.34%) school children mother occupation were home maker.
- In the present study, the majority of school children 36(60%) were from urban area.
- In the present study the majority of 26(43.33%) school children were got information from mass media.
- The mean pretest knowledge score was 9.8833 and the mean posttest knowledge score was 15.366.
- The mean pretest expressed practice score was 37.933 and the mean posttest expressed practice score was 55.316.
- The difference between the knowledge score of pretest and posttest ($p < 0.05$) was 5.4833. The difference was the net benefit to the group due to child-to-child programme.
- The difference between the expressed practice score of pretest and posttest ($p < 0.05$) was 17.383. The difference was the net benefits to the group due to child-to-child programme.
- The correlation between the pretest knowledge and the pretest expressed practice was 0.46 and the posttest knowledge and the posttest expressed practice was 0.62.
- Out of the several socio demographic variables in the group, there was a statistical association between pretest knowledge score and gender of the school children.
- Out of the several socio demographic variables in the group, there was a statistical association between pretest expressed practice score and type of family of the school children.

IV. Interpretation

The findings of the study clearly proved that the child-to-child programme was effective in improving knowledge and expressed practice regarding ways to improve physical and mental health among school children.

Regarding the percentage of pretest knowledge score of subjects 43(71.67%) had inadequate knowledge, 17(28.33%) had moderate knowledge and none of them had adequate knowledge when compared with the percentage of posttest knowledge score 40(66.67%) had adequate knowledge, 20(33.33%) had moderate knowledge and none of them had inadequate knowledge.

Regarding the percentage of pretest expressed practice score of subjects 13(21.67%) had poor expressed practice, 46(76.66%) had moderate expressed practice and 1(1.67%) had Good expressed practice, when compared with the percentage of posttest score 50 (83.33%) had good expressed practice, 10(16.67%) had moderate expressed practice and none of them had poor expressed practice.

V. Conclusion

From the findings of the present study, it was concluded that the level of knowledge and expressed practice of school children regarding ways to improve physical and mental health among school children was inadequate during the pretest assessment. However, the findings of the posttest in the group showed that the level of knowledge and expressed practice had improved. The improvement was due to the administration of the child-to-child programme. Therefore, the knowledge and expressed practice of the school children could be further improved by providing on going education programmes.

So, this study brought out the conclusion, that lack of awareness and poor practices create a serious public health threat to school children. School health is an important intervention as a great deal of research tells us that schools can have a major effect on children's health by teaching them about health and promoting healthy behaviour. Promotion of healthy practices in schools by health care providers and school teachers through new creative methods of teaching such as child to child programme could be an effective means of communication regarding health issues and health promotion among children.

Imparting these child-to-child programme concepts to Nursing students and Community health worker and its utilization to provide health education in the schools, hospitals and communities could be used for spreading the health messages among school children. Therefore, awareness regarding the promotion of health and the prevention of diseases through healthy practices can be promoted today and for the future generations.

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