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INFLUENCE OF HEALTH KNOWLEDGE ON THE DEVELOPMENT OF HEALTHFUL BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS IN NASARAWA STATE

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ABSTRACT

The general aim of health education programme in secondary school is to bring about positive change in the behaviour of the students. This study was carried out to find out the influence of health knowledge on the development of positive behaviour among the students of secondary schools in Nasarawa State. A questionnaire was developed, validated and pilot test for reliability. Four hundred and fifty (450) students were randomly sampled from four schools, two urban and two rural. Mean and standard deviation, t-test, correlation coefficient and ANOVA statistical techniques were used to test the hypotheses. The main finding revealed that students' health knowledge, health attitude and health practices were negative. It was recommended that teaching of health education should be improved in order to encourage development of healthful behaviour.
Key Words: Health Knowledge, Health Practice, Health Attitude, Positive Behaviour.

INTRODUCTION

The accomplishment of the set objectives of health education in secondary schools will determine to a large extent desirable health knowledge, attitude and practices of the students. Ajisafe (1980), Usman (2006) reported that the planned school health education activities do not seem to produce perceived desirable health education outcomes which are reflected in health knowledge, attitude and practices. Sanusi and Igbanugo (2001), Usman (2006) reported that the general wellbeing and lifestyle of students particularly in Borno State do not seem to reflect positive health knowledge, attitude and practices. The general observation of poor health behaviour seem to have similarities with other states in Nigeria. The general belief has been that health education programmes of secondary schools produce limited desirable results, especially in health attitude and practices. However, such beliefs are supported by very few objective evidence. It is therefore, necessary to find out the changes that are brought by health education programmes in students in Nasarawa State which has been the focus of this research.

METHOD

An expost-factor design was used. A population of four hundred and eight (480) were randomly selected from senior secondary school students. Two all-girls and two all-boys secondary schools were purposively selected for the study. Namely government girls college Keana, government girls secondary school Wamba, government science school Nasarawa and government college Keffi. Forty two (42) students were systematically chosen in each group of SSS_1, SSS_2 and SSS_3 in each school visited. A questionnaire was developed by the researcher to obtain the required information. It was validated and tested for reliability and 0.67 was found. One hundred and twenty copies of the questionnaire were distributed to the respondents in each school. The analysis was based on four hundred and fifty (450) copies of duly completed questionnaire copies. Two hundred and twenty three (223) respondents were female while two hundred and twenty seven (227) respondents were male. Students t-test, Pearson product movement correlation, multiple regression and mean analyses were used.

RESULTS

The analyses were presented in the following order. Hypothesis one: Health knowledge, health attitude and health practices of secondary school students in Nasarawa State are not positive. To test the hypothesis, mean and standard deviations of responses to statements on health knowledge, attitude and practices were computed and reflected in table 1

Table 1: *Means and standard deviations of responses to statements of health knowledge, health attitude and health practices*

Variable	No. of Statements	Mean	SD	Mean Minimum	Mean
Health knowledge	21	3.1848	.3503	1.000	5.000
Health attitude	20	3.2312	.3302	1.000	5.000
Health practice	20	3.3527	.3493	1.000	5.000

Significant at 3.5 and above

The table 1 reflects that the health knowledge, health attitude and health practices of secondary school students in Nasarawa State were not positive. This is due to the fact that the mean scores of these variables were 3.1848 ± .3503, 3.2312 ± .3302 and 3.3527 ± .3493 respectively as compared against 3.5 mean. The hypothesis is accepted. Table 2 reflects the correlations between health knowledge, health attitude and health practices of secondary school students in Nasarawa State. A hypothesis was raised to this effect. Thus, there is no significant relationship between health knowledge with health attitude and health practices of secondary school students in Nasarawa State.

Table 2: *Intercorrelations between health knowledge with health attitude and health practices*

	Health knowledge	**Health attitude**	**Health practice**
Health knowledge	1.0000	.4588	.2885
Health attitude	.4588	1.0000	.4398
Health practice	.2885	.4398	1.0000

r (450) = 1.95 <.05

The table 2 indicate insignificant correlation among knowledge, health attitude and health practices of secondary school students in Nasarawa State, as indicated, .4588, .2885, and .4398 respectively. Therefore, the hypothesis is accepted. Tables 3 reflect the difference between male and female secondary school students. The hypothesis raised was that, there is no significant difference between male and female secondary school students in their health knowledge, health attitude and health practices in Nasarawa State.

Table 3 **T-test for difference between male and female respondents in their health knowledge, health attitude and health practices**

Variable	Gender	Mean	SD	SE	t-value	DF	P
Health knowledge	Male Female	3.2259 3.1429	.384 .308	.025 .021	2.53	448	.012
Health attitude	Male Female	3.2029 3.2601	.371 .280	.025 .019	-1.84	448	066
Health practice	Male Female	3.3040 3.4022	.346 .346	0.23 .023	-3.01	448	.003

t (4.50) = 1.96 < .05

Table 3 indicate significant difference in health knowledge and health practice between male and female secondary school students as indicated by a t-value of 2.53 and -3.01 as compared with 1.96 respectively. They did not significantly differ in their attitude toward health as indicated by t-value of -1.84 as compared with the critical t-value of 1.96. Table 4 reflect result on difference between rural and urban secondary

school students. The hypothesis raised to this effect was that, there is no significant difference between rural and urban secondary school students in their health knowledge, health attitude and health practices in Nasarawa State.

Table 4: **T-test for difference between urban and rural respondents in their health knowledge, health attitude and health practices.**

Variable	Location	Mean	SD	SE	t-value	DF	P
Health knowledge	Urban Rural	3.1404 3.2239	.368 .330	.025 .021	-2.54	448	.011
Health attitude	Urban Rural	3.1763 3.2797	.343 .311	.024 .020	-3.35	448	001
Health practice	Urban Rural	3.3078 3.3923	.376 .320	0.26 .021	-2.58	448	.010

$t(4.50) = 1.96 < .05$

Table 4 indicate significant difference in health knowledge, health attitude and health practices between urban and rural secondary school students in Nasarawa State as indicated, -2.54, -3.35 and -2.58 as compared with critical value of 1.96 respectively. Therefore, the hypothesis is rejected. Students in the rural areas are better in health knowledge, health attitude and health practices than their counterpart in the urban areas. Table 5 reflect result on differences among the class levels of secondary school students. The hypothesis raised to this effect was that, there is no significant difference among the students of SSS_1, SSS_2, and SSS_3 in their health knowledge, health attitude and health practices.

Table 5: One way analysis of variance of the health knowledge, health attitude and health practices

Source	DF	Sum of squares	Mean squares	F-value	P
Health knowledge					
Between groups	2	.3590	.1795	1.4657	.2320
Within groups	447	54.7420	.1225		
Total	**449**	**55.1010**			
Health attitude					
Between groups	2	.7673	.3837	3.5597	.0293
Within groups	447	48.1765	.1078		
Total	**449**	**48.9438**			
Health practice					
Between groups	2	.0912	.0456	.3726	.6891
Within groups	447	54.6856	.1223		
Total	449	54.7768			

$F = 3.84$; $df = 479$; $P < 0.05$

Table 5 indicate insignificant difference in health knowledge, health attitude and health practices among the class levels of the respondents in Nasarawa State as indicated, 1.4657, 3.5597 and .3726 as compared with the critical value of 3.84 respectively. Therefore the hypothesis is accepted.

DISCUSSION

The aimed of this study was to find the influence of health knowledge on the development of healthful behaviour among secondary school students in Nasarawa State. Health education programme in secondary schools is meant to improve healthy behaviour. Unless there is a change in behaviour before we can say

health education programme is effective. The results of the study showed that health knowledge of secondary school students in Nasarawa State was negative. It is a general consensus among educators that formal teaching of health education equip the learner with health knowledge. The result of this study is inline with Umaru (2008 and 2003) who reported negative health knowledge acquired by primary school pupils and secondary school students. Sanusi and Igbanugo (2001) and Usman (2006) reported positive health knowledge among secondary school students in Borno State. This could be as a result of greater emphasis placed on examination results rather than on affective domain of learning. The study further reveals negative health attitude and health behaviour among the respondents. The results supported that of Sanusi and Igbanugo (2001), Usman (2006) and Umaru (2003, 2007 and 2008) who had reported negative health attitude and health practices among their subjects. It is believed that positive health knowledge would influence positively health attitude and Health practices, because improve in knowledge equip the individual to better handle new problems.The study further reveals insignificant relationship among health knowledge, health attitude and health behaviour of secondary school students in Nasarawa State. Lack of significant influence of health knowledge on the other variables is not surprising, because the acquired health knowledge was negative. Who (1969) reports that what we decide about it and what we do about it are in the realm of application of knowledge gained. Therefore, where the acquired knowledge is negative, the possibility of application of the knowledge is very low. Contrary to this study was the finding of Usman (2006) who found a significant relationship among his subjects. This is because he found positive health knowledge among the subjects which reflected in their practices. This study reveals significant difference in gender, when their health knowledge and health behaviour were compared. Such differences were in health knowledge and health practices, while no difference was found in their health attitude. Female students were better in health practice while the male students were better in health knowledge. The better health behaviour exhibited by the female could be as a result of the rapid physiological changes taking place in them which demands for the need to attract the opposite sex. Usman (2006) found difference in health knowledge and health attitude in favour of male while Umaru (2008) found difference in health knowledge and health attitude in favour of female respondents. The study further reveals significant difference between urban and rural respondents. Rural respondents were found to be better in health knowledge, health attitude and health practices. This could be due to the fact that both the urban and rural areas in Nasarawa State were about the same in development with few schools scattered everywhere, with similar characteristics. Usman (2006) and Umaru (2008) reported differences between urban and rural areas respondents in their health knowledge, health attitude and health practices in favour of urban areas. This is because the states from which the data were collected were more developed than Nasarawa State. The study further reveals insignificant difference among the class levels of the respondents in their health knowledge, health attitude and health practices. This finding is contrary with that of Umaru (2008) and Usman (2006) who found differences in health knowledge, health attitude and health practices among their subjects. Difference in development among the States where data were collected was responsible for the difference.

CONCLUSION

Based on the results obtained from the study and within it limitations, the following conclusions were drawn.

- The students' health knowledge, health attitude and health practice were negative.
- The students' health knowledge did not influence their health behaviour
- The male and female students differ in their health knowledge and health practices.
- The male and female students did not differ in their health attitude.
- The urban and rural students differ in their health knowledge, health attitude and health practices in favour of rural area.
- The class levels of the students did not differ in the level of health knowledge, health attitude and health practices.

RECOMMENDATIONS

Based on the conclusions, the following recommendations were made;

- Teaching of health education programme in secondary schools in Nasarawa State should improve. This will encourage the development of healthy behaviour among the students.

- Teachers handling the health education programme in secondary schools should make sure that teaching of health education is oriented toward changing the behaviour of students.
- Health education programme should cover both junior and senior secondary schools in Nasarawa State so that the benefit of the programme will be felt through out the time they spent in school.

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