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IMPACT OF HEALTH KNOWLEDGE ON HEALTH ATTITUDE AND HEALTH PRACTICES AMONG SECONDARY SCHOOL STUDENTS IN OYO STATE, NIGERIA

By

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Abstract

Health education programmes in secondary schools assist students to acquire knowledge and skills that would produce and maintain an environment free of diseases. The purpose of this study was to find out the impact of health knowledge on health attitude and health practices among the students of secondary schools in Oyo State. A questionnaire was developed, validated and pilot tested for reliability. Four hundred and seventy (470) 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 healthy practices.

Introduction

Health knowledge is extremely diverse in scope. It involves personal hygiene, environmental hygiene, human body mechanism, consumer education, first aid and safety education, social, mental and emotional health, family life education, Nutrition, drug, alcohol and tobacco education, nature, prevention and control of communicable diseases, sex education, among others. Therefore, acquisition of health knowledge that is used to help in solving health problems and make the young generation adequately informed which prepare them to have direct influence in determining the

health of still another generation of young people – their own children (Umaru, 2010).

However, due to bad attitude as manifested through faulty approach to our health issues, people dump refuse into gutters, streams, river sides, and any available open space, urinating in corners, indiscriminate defaecation, littering of surroundings and streets, cluster housing systems with poor ventilation, damp and inadequate sanitary facilities forming slums, which breed diseases on large scale (Umaru, 2008a, 2008b, 2008c, 2007a, 2007b, 2003; Suleiman & Umaru, 2006; Umaru & Suleiman, 2001). Most of these are common features in secondary schools in Nigeria. Secondary school students are fond of living in unhygienic school environment which is partially due to inadequate sanitary facilities and partially to unhealthy attitude formed at home. Several investigations have reported cases of poor sanitation which were linked to disease occurrence (Stubbs, 1991; Ayanda, 1991; Population report, 1992; Cartbell, 2000; Suleiman, 2003). The researchers aim at assessing students' level of present health knowledge, desirable health attitude, desirable health practices, impact of health knowledge on these variables, as well as difference between male and female students in their health knowledge, attitude and practices. This would assist in finding out the changes that are brought by health education programmes in Oyo State which was the focus of this research.

Method

An ex-post-facto research design was used. A sample of four hundred and eighty (480) was randomly selected from senior secondary school students. Two all-girls and two all-boys secondary schools were purposively selected for the study. Namely St. Anne Molete Girls Secondary School Ibadan, Ogbomosho Baptist Girls High School, Ibadan Boys High School Oke-Bola, and Loyola College Egbeda Ibadan. Forty two (42) students were systematically selected in each group of SSS₁, SSS₂ and SSS₃ in each school visited.

A questionnaire was developed by the researchers 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 seventy (470) copies of duly completed questionnaire copies.

Two hundred and thirty one (231) respondents were female while two hundred and thirty nine (239) respondents were male. Students t-test, Pearson product movement correlation, ANOVA and mean analyses were used.

Results

The analyses were presented as follow. Hypothesis one: Health knowledge, health attitude and health practices of secondary school students in Oyo State are not positive. To test the hypothesis, means 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	3.2848	.3603	1.000	5.000
Health attitude	20	3.3312	.3402	1.000	5.000
Health Practice	20	3.4427	.3593	1.000	5.000

Significant at 3.5 and above

The table 1 reflects that health knowledge, health attitude and health practices of secondary school students in Oyo State were not positive. This is seen from the mean scores of these variables being presented in the above table as $3.2848 \pm .3603$, $3.3312 \pm .3402$, and $3.4427 \pm .3593$ – 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 Oyo State. A hypothesis was raised: there is no significant

relationship between health knowledge with health attitude and health practices of secondary school students in Oyo State.

Table 2: Intercorrelations between health knowledge, health attitude, and health practices

	Health knowledge	Health attitude	Health practice
Health knowledge	1.000	.4488	.3588
Health attitude	.4488	1.000	.4389
Health practice	.3588	.4389	1.000

$r(470) = 1.95 < .05$

The table 2 indicates significant correlations among health knowledge, health attitude, and health practices of secondary school students in Oyo State as indicated, .4488, .3588, and .4389 respectively. The hypothesis is rejected.

Table 3 reflect the difference between male and female secondary school students in their health knowledge, health attitude and health practices in Oyo State.

Table 3: t-test for differences 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	3.3259	.385	.026	2.54	468	.013
	female	3.1539	.309	.022			
Health attitude	male	3.3039	.372	.026	- 1.85	468	.067
	female	3.3760	.281	.020			
Health practice	male	3.4040	.347	.024	- 3.02	468	.004
	female	3.5022	.347	.024			

$t(468) = 1.96 < .05$

Table 3 indicates significant differences in health knowledge, health attitude, and health practices between male and female secondary school students as indicated by a t-value of 2.54 and - 3.02 as compared with 1.96 respectively. They did not significantly differ

in their attitude toward health attitude as indicated by a t-value of 1.85 as compared with the critical t-value of 1.96.

Tables 4 reflect result on difference between rural and urban secondary school students. The hypothesis raise was that, there is no significant difference between rural and urban secondary school students in their health knowledge, health attitude, and health practices in Oyo State.

Table 4: t-test for differences between urban and rural respondents in their health knowledge, health attitude, and health practices.

Variable	Gender	Mean	SD	SE	t-value	DF	P
Health knowledge	urban	3.2405	.369	.026	-2.56	468	.012
	rural	3.3349	.331	.022			
Health attitude	urban	3.2863	.344	.025	- 3.36	468	001
	rural	3.3897	.312	.021			
Health practice	urban	3.4078	.377	.027	- 2.58	468	.011
	rural	3.4823	.321	.022			

$$t(468) = 1.96 < .05$$

Table 4 indicates significant differences in health knowledge, health attitude, and health practices between urban and rural secondary school students in Oyo State as indicated, - 2.56, - 3.36, 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 counterparts in the urban areas.

Table 5 reflect differences among the class levels of secondary school students. The hypothesis raised was that, there is no significant difference among the students of SSS₁, SSS₂, and SSS₃ 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

Health knowledge					
Source	DF	Sum of Squares	Mean Squares	F-value	P
Between groups	2	.3691	.1895	1.5657	.2420
Within groups	467	55.8420	.1336		
Total	469	56.2111			
Health attitude					
Between groups	2	.7783	.3947	3.6597	.0393
Within groups	467	49.2765	.1188		
Total	469	50.0348			
Health practice					
Between groups	2	.0922	.0557	.3837	.7991
Within groups	467	55.7866	.1334		
Total	469	55.1788			
F = 3.84; df = 469; P < .05					

Table 5 indicates insignificant differences in health knowledge, health attitude, and health practices among the class levels of the respondents in Oyo State as indicated, 1.5657, 3.6597, and .3837 as compared with the critical value of 3.84 respectively. Therefore, the hypothesis is accepted.

Discussion

The aimed of the study was to find the impact of health knowledge on health attitude and health practices among secondary school students in Oyo State. Any health education activity in the schools is meant to improve healthy attitude and practices among the beneficiaries. Therefore, it is a fact that only when changes take effect in behaviour, then health knowledge has effect on the students. The result of the study revealed negative health

knowledge. This indicate general problem in achieving the set desire objective of health education in schools. This result is in line with Umaru (2008a, 2008b, 2008c, 2003) who reported negative health knowledge acquired by both primary school pupils and secondary school students. However, 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 offering Health Science and physical education in the schools.

The study further revealed negative health attitude and practices among the respondents. The results supported that of Umaru (2007a, 2007b), Sanusi and Igbanugo (2001), Usman (2006) who had reported negative health attitude and health practices among their respondents. Acquisition of health knowledge couple with enabling environment would create impact on building positive health attitude which will be translated into positive health practices among the students. This is because gain in health knowledge improve the frontier of knowledge acquired by the student which assist the individual to better handle new problems. The study further revealed significant relationship among health knowledge, health attitude, and health practices denoting an impact of health knowledge on the other variables as found in Oyo State. This has indicated that the low level of health knowledge acquired by the students has affected their health attitude and health practices which were found to be negative. WHO (1969) reported that acquisition of knowledge is all about application and where application of knowledge gained is not achieve, the knowledge gained equal no knowledge. This fact buttressed the finding of Usman (2006) who reported significant relationship among his subjects. This is because he found positive health knowledge among the respondents reflecting in their health practices. This implies that both positive and negative health knowledge would affect practices in either way. The study revealed significant differences in gender in their health knowledge and health practices, but no significant differences were revealed in health attitude. Female respondents have better health practices while male respondents were better in health knowledge. The rapid physiological changes in female could account for the better health practices they exhibited. Usman (2006) found differences in health knowledge and health attitude in favour of

male, while Umaru (2008D) found differences in health knowledge and health attitude in favour of female respondents. The study revealed significant difference between urban and rural respondents in favour of rural areas. This could be due to the availability of enabling environment than the urban settlements. However, Usman (2006) and Umaru (2008D) reported differences between urban and rural areas in favour of urban areas. This could be due to the fact that the states where they collected data were less populated than Oyo State. The study further revealed insignificant differences among the class levels of the respondents in their health knowledge, health attitude and health practices. This finding is contrary to that of Usman (2006) and Umaru (2008D) who found differences in health knowledge, health attitude, and health practices among their respondents. These differences were as a result of differences in development among the states where data were collected.

Conclusion

Based on the results obtained from the study and within its limitations, the following conclusions were drawn:

- The students' health knowledge, health attitude and health practice were negative.
- The health knowledge acquired by the students does not create positive impact on the health attitude and health practices.
- 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:

- 1 The teaching of health education in secondary schools in Oyo State should be improved. This will encourage the development of healthy practices among the students.

- 2 The teaching of health education in secondary schools should be re-oriented toward application of the knowledge gained.

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