Evaluate the Effectiveness of Planned Teaching Programme on Knowledge Regarding Impact of Tobacco use Among Adolescents in Selected Pu Colleges at Nagamangala (Tq) Mandya (District)

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A B S T R A C T

Tobacco smoking is most popular form of smoking, practiced by over one billion people leading to health problems. Nurses have an important role in prevention of smoking by conducting educative programmes on ill effects of smoking in Colleges, and also in hospitals. This study attempts to evaluate the effectiveness of planned teaching program on knowledge regarding impact of tobacco use among Adolescents in selected P U college at Nagamangala (tq) Mandya (district).

Keywords: P U College students; planned teaching program; Impact of tobacco use.

Introduction

Health is a wealth and wonderful gift given by GOD. It's our duty to preserve it to lead a healthy life. Good health is a priceless asset. But some people, for seeking temporary pleasure fall into bad habits such as chewing tobacco. The personal decisions on behavior affect the prospects for good health and that ill health is not solely a consequence of illume but frequently a direct consequence of behavior under individual's control.[1]

Tobacco consumption is preventable cause of death in the world. The negative impacts of tobacco use on the human body are more. it increases the risks for cancers at 13 sites, particularly the lung, and for heart disease, stroke, and chronic obstructive pulmonary disease. Combusted tobacco products kill up to one-half or more of all people who use them, on average 15 years prematurely. Today, tobacco use causes 12% of deaths among adults worldwide, representing almost 6 million people a year. Yet, tobacco products continue to be among the most widely consumed products globally. Unless tobacco use is markedly reduced, it has been estimated that 1 billion people worldwide will have died as a result of using tobacco products by the end of the twenty-first century. Manufactured cigarettes are the predominant form of tobacco used worldwide. In 2016, manufactured cigarettes accounted for 95% of total smoked tobacco sales, with cigars and other smoked tobacco such as roll-your-own cigarettes, pipes, bidis, and kreteks accounting for the remainder. Various forms of oral smokeless tobacco are common in Southeast Asia and the Middle East and regionally are popular in parts of Europe , as well as the United States.[2]

The Portuguese introduced tobacco to India 400 years ago and established the tradition of tobacco trader in their colony of Goa. 200 years later, the British introduced commercially produced cigarettes in India.4 the United States Surgeon General Report 1988 reported that cigarette as well as other forms of tobacco are addicting. The pharmacological and behavioral processes that determine tobacco addiction is similar to those processes determine addiction to drugs like heroin and cocaine.5 before it was established that nicotine was psychoactive drug; tobacco dependence was not fully recognized as a substance abuse disorder. In 1980, however the APA in its DSM of mental disorders included tobacco dependence as a substance abuse disorder. Subsequently this classification was developed and strengthened. In the WHO'S ICD (10th version 1990) tobacco is dealt within the section entitled mental and behavioral disorders due to psychoactive substance use.6 Drug addiction is neither delinquency nor deviancy, but it is a disease worse than cancer. It is a 4 disease because it affects physical health, mental health, prestige, finance, social status and occupation of the individual. [3]

James "Buck" Duke formed the American Tobacco Company in the US (1889). Utilizing Virginia inventor James Bonsack's cigarette rolling machine, he made 200 cigarettes a minute. Within five years one billion cigarettes were produced. The sale of Duke's cigarettes exploded, leading the way to the production of 30 cigarettes a second and the sales of approximately six trillion cigarettes worldwide in 2014 . As this century progresses, we are seeing the tobacco industry expand their sale of cigarettes into Asia, the Middle East and Africa as the market in developed countries shrinks, and as a global health treaty (FCTC), has been introduced to reduce tobacco related diseases.[4]

There is an acknowledgment amongst health care professionals that working with tobacco and nicotine using patients to quit their addiction is one of the most difficult tasks they are asked to perform. The obligation and duty of a healthcare provider is to prevent disease, thus we ideally should be speaking

to parents and their children about the dangers of tobacco use as early as is feasible as most smokers begin using cigarettes between the ages of 10-13. This is especially true given the viral rise in the number of young people vaping. In addition, "Secondhand smoke exposure causes disease and premature death in children who do not smoke. Children exposed to second hand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.[5]

Among young smokers. The smokers are also at great risk of many other nonfatal diseases, including osteoporosis, periodontal disease, impotence, male infertility, and cataract. Smoking in pregnancy is associated with increased risk for reduced birth weight for gestational age. Tobacco is not just a simple health issue, but involves economics, environment, big business, politics, family relations, trade and crimes such as smuggling, litigation and deceit. [6]

OBJECTIVES

1. To assess the pretest level of knowledge among adolescents on impact of tobacco use in selected PU colleges.

2. To evaluate effectiveness of planned teaching program on knowledge regarding impact of tobacco use among adolescents in selected PU colleges

3. To assess the posttest level of knowledge among adolescents on impact of tobacco use in selected PU colleges.

4. To find association between pretest knowledge scores with selected demographic variables

METHODS

The study involved one group pre-test and post-test without a control group using pre-experimental design, with non-probability sampling technique in which purposive sampling method was used. 60 Government P U College, Bellur , Nagamangala (TQ) Mandya (D) students were made to mark the planned questionnaire followed by implementation of PTP and post- test conducted after 8 days, using the same planned questionnaire to find out the effectiveness.

MAJOR FINDINGS OF THE STUDY

Maximum 59 (98%) adolescents in selected P U colleges at Nagamangala (TQ) were the age between 16- 18 years and 1 (2%) adolescent in selected P U colleges at Nagamangala (TQ) were the age between 18- 19 years. Maximum 22 (37%)adolescents in selected P U colleges at Nagamangala (TQ) are Male and 38 (63%) adolescents are Female. 39 (65%) adolescents in selected P U colleges at Nagamangala (TQ) were Hindu 4 (7%) adolescents are christian , 15(25%) adolescents are muslim and 2(3%) adolescents are other religion. 36 (60%) adolescents in selected colleges at Bangalore were from nuclear family 24   (40%)adolescents from Joint family . 42 (70%) adolescents in selected colleges at Bangalore were from of rural area, 18 adolescents from urban area. 7 (%) adolescents' father's educational status is illiterate , 37 adolescents father's educational status is primary 10 adolescents father's educational status is secondary school , and 6 adolescents father's educational status is graduate. 12(%) adolescents' mother's educational status is illiterate , 37 adolescents mother's educational status is primary 9 adolescents mother's educational status is secondary school , and 2 adolescents mother's educational status is graduate.; 10 (%) adolescents fathers occupation are unemployed , 36 (%) adolescents fathers occupation are daily wage earner, 11 (%) adolescents fathers occupation are self employed, and 3 (%) adolescents fathers occupation are Government; 26 (%) adolescents mother's occupation are unemployed , 25 (%) adolescents mother's occupation are daily wage earner, 9 (%) adolescents mother's occupation are self employed ; 44(%) adolescents in selected P U colleges at Nagamangala (TQ) were having the family monthly income of Rs.below 20000/- , 15 adolescents were having the family monthly income of 20000- 45000, 1 adolescent were having the family monthly income of above 1 lakh ; 17 (%) adolescents in selected P U colleges at Nagamangala (TQ) were having the family history of smoking and 43 adolescents not having family history of smoking; 12(%) adolescents in selected selected P U colleges at Nagamangala (TQ) got information regarding ill effects of tobacco use from health team members, 6 adolescents got information regarding ill effects of tobacco use from parents/ friends/ relatives, 6 adolescents got information regarding ill effects of tobacco use from social media and 36 adolescents does not got information regarding ill effects of tobacco use; 52 % had inadequate knowledge, 45% had moderate knowledge where as in post test 2% of the samples reached moderate knowledge 98% of the samples reached adequate knowledge. This shows an improvement in knowledge level after planned teaching programme.

INTERPRETATION AND CONCLUSION

In this study the Calculated 't' value 3.77 is higher than the tabulated 't' value of 1.671. So the H1 hypothesis accepted. The researcher concluded the teaching was effective. There is a significant association between post test knowledge level and the socio demographic variables such as sex, religion fathers education status, fathers occupation, mothers occupation, family history of tobacco use, source of information regarding impact of tobacco use, as the chi-square value is higher than the table value at 0.05 level of significance. Therefore, it accepts the H2 hypothesis.

The overall findings of the study clearly showed that the PTP was significantly effective in improving the knowledge scores of P U College students regarding Impact of tobacco use.

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