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Effect of Planned Teaching Programme on Knowledge Regarding Ill-Effects of Passive Smoking on Children among Parents of Under Five Years Children of a Selected Rural Community of South 24 Parganas, West Bengal

Sreeparna Ghosh[1], Kuntal Mondal[2]
[1]*Faculty, Govt. College of Nursing Diamond Harbour Govt. MCH, PhD Scholar of SJJT University*
[2]*Vice Principal, Sister Nibedita University, M.Sc. Nursing (Community Health Nursing)*

Abstract: ***This study is entitled to assess the effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children among parents of under five years children of a selected rural community of south 24 parganas, West Bengal. The objective of the study was to determine the effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children. The investigator adapted pre-experimental research approach with one group pretest post test research design. She selected 60 parents (fathers) by non probability purposive sampling technique. Data was collected with valid and reliable structured interview schedule. The findings of the study revealed that mean post test knowledge score of parents (fathers) is significantly higher than the pretest knowledge score with a mean difference of 5.27 from 't' value 9.06 at 0.05 level of significance after their exposure to planned teaching programme regarding ill-effects of passive smoking on children and there was no significant association with pretest knowledge score and selected variables. Therefore planned teaching programme was an effective method of imparting knowledge of parents (fathers). Study has implications on nursing service, nursing education and nursing research. This study can be repeated with a larger sample in another setting with other teaching strategies.***

Keywords: Passive smoking, Planned Teaching Program, Ill-effects of passive smoking, Parents of under five years children, Knowledge

I. INTRODUCTION

A. Background of the Study

" Papa don't smoke it hurts us."

Health and illness underpin our everyday existence. Health allows us to live fill lives and to function as social beings. Illness disrupt our lives, sometimes seriously. But health not only affects individuals, it also has an impact upon society as a whole. The children of today are the resources of the future. Preservation of their lives will always be priority. Child health includes the care of the children from infancy adolescence. Most of the children experience one or more episodes of illness.[1]

Aguayo S.M. in her study increased level of bombesin like peptides in the lower respiratory tract of symptomatic cigarette smokers said smoking is an addiction of tobacco products, which is the second most preventable causes of premature death in India. Smoking cigarettes affect the smokers and non-smokers equally to over 400 chemicals of tobacco products, many of which are toxic in nature, they are Tar, Hydrogen cyanide, Benzene, Acetone, Formaldehyde, Ammonia, Carbon monoxide and Nicotine. People close to a smoker can also experience dangerous effects of tobacco smoke due to inhalation of second hand smoke and are considered as passive smokers. Passive smoking is involuntary inhalation of diluted side stream smoke and main stream smoke in the closed or open environment.[2]

W.H.O. in their module Second hand tobacco smoke and children said passive smoking causes many detrimental health effects on adults and children .The children under five years of age are at risk to get ill effects of passive smoking due to their rapid respiration comparing others. When other smokes the air sustains in the environment will be inhaled by the children with a higher concentration of toxins in smoke.

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So passive smoking is also named as environmental tobacco smoke . Children with smoking fathers are prone to develop rhabdomyosarcoma, neuroblastoma and brain tumour. Smoking is set to kill 6.5 million people in 2015 and 8.3 million humans in 2030, with the biggest rise in low-and middle-income countries. Every 6.5 seconds a current or former smoker dies, according to the World Health Organization (WHO).[3]

Glantz S. in his study Reduced incidence of Admission for Myocardial Infarction Associated with public smoking ban assessed tobacco use and exposure to second hand smoke during pregnancy are major health threats in several low income countries like India. The prevalence of tobacco exposure among women in India ranges from 10-62%. Results revealed that passive smoking may be implicated in deteriorating cardiovascular status in children in terms of unfavorable high-density lipoprotein levels and deteriorated vascular function.[4]

Fernando D. et al in their study Increased incidence of Asthma in Children of Smoking Mothers assessed in children, Environmental Tobacco Smoke (ETS) is associated with an increased risk of lower respiratory tract infections (LRTIs), such as bronchitis and pneumonia. An estimated 150,000-300,000 cases of LRTIs in children younger than 18 months are attributed to ETS annually. ETS is causally associated with increased prevalence of fluid in the middle ear, upper respiratory tract irritation, and reduced lung function. It is also associated with increased severity of asthma in children; the asthma of an estimated 200,000-1,000,000 children is worsened by ETS. Finally, ETS is a risk factor for the development of asthma in children.[5]

Daniel R. in his study Second Hand Smoke Survey for Central and Western Minnesota explored die of lung cancer and 35,000 die from heart disease as a result of second hand smoke , according to the Centers for Disease Control and Protection . An overwhelming majority of respondents belief that while second hand smoke is harmful to both adults and children , four in ten respondents strongly agreed that second hand smoke is harmful to children . The vast majority of respondents belief that children are more likely to become smokers if they are used to seeing adults around them smoke .[6]

A Report of the Surgeon General, U.S. DDHS, Public Health Service explored worldwide approximately 1.3 million people currently smoke cigarettes and other tobacco products . World smokers are estimated by the year 2025/30 is about 10 million, passive smoking causes the death of 4,40,000 people in a year in U.S.A. 1,21,000 people dies per year and 330 people per day in U.K. 7,000 people in Ireland, 9.5 million per year in Scotland, 50 % of passive smokers in Asia, 53 % in Japan, 63 % in China and 3000 to 5000 deaths in France. The non smokers are affected by passive smoking about 82 % of stroke, 48 % of cancer, 25 % heart disease, 25 % of lung cancer, 75 % breast cancer, 40 % asthma and 40 % of sudden child death syndrome.[7]

W.H.O. / WPRO in their Smoking Statistics World Health Organization Regional Office for the Western Pacific that a study conducted on 2008 by Department of Health Sciences of financial cots of passive smoking the estimated primary care visits by children costing £ 9.7 m and hospital admissions costing £ 13.6 m every year. Providing children with drug to treat asthma developed as result of passive smoking costs a further £ 5.7 m annually and smoking breaks may be as much as £ 5.6 m every year. [8]

Cao S.,Yang C.,GanY. and Lu Z in their study The Health Effects of Passive Smoking : An Overview of Systematic Reviews Based on Observational Epidemiological Evidence aim to systematically summarize the available epidemiological evidence to identify the impact to environmental tobacco smoke on health. A systematic literature search of pubmed, Embase, web of science and Scopus for meta-analyses was conducted through January 2015. We included systematic reviews that investigated the association between passive smoking and certain diseases.

Quantitative outcomes of association between smoking and risk of certain diseases were summarized. Our over view of systematic reviews of observational epidemiological evidence suggests that passive smoking is significantly associated with an increasing risk of many diseases or health problems, especially diseases in children and cancers.[9]

Cook G. D. and Strachan D.P. in their study Parental smoking, Bronchial reactivity and peak flow variability in Children a systematic quantitative review was conducted of the evidence relating environmental tobacco smoke to bronchial hyper responsiveness (B.H.R.) during childhood. 29 relevant studies were identified after consideration of 1593 articles selected by electronic search of the Embase and Medline databases using keywords relevant to passive smoking in children. The search was completed in April 1997. Of 19 studies using challenge test in children of school age, 10 (5759 children) could be summarized as the odds ratio of being bronchial hyper responsive in children exposed to environmental tobacco smoke compared with those not exposed. However in 5 further studies of 3531 children providing some evidence, but not odds ratios, none were statistically significant. A further 4 studies of circadian variation in peak expiratory flow found increased variation in children exposed to environmental tobacco smoke. [10]

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B. Need of the Study

" Make the environment smoke free and allow the children to grow free ."

Chandra R.K. in her article Iron Rich foods wrote Passive smoking is the inhalation of smoke from tobacco products used by others it is also called as second hand smoking or environmental tobacco smoking . Smoking parents are making their children as passive smokers irrespective of age and sex. Even the fetus of antenatal women receives high level of nicotine from her blood. Children between 0-5 years of age are more prone to affect by passive smoking . A smoking father causes many health hazards to his children and wife . The mortality and morbidity rates are high among children with smoking parents, mainly due to ill-effects of passive smoking are caused by the toxins and carcinogens present in tobacco products while smoking.[11]

Eichton wald H. found in his study preventive measures of ill effects of passive smoking are to be begun from home itself. The fathers who smokes at home is to stop smoking at home and its surroundings, when the parent smokes their children coughs which gives the signal " Papa don't smoke, it hurts us". The children with smoking fathers should wear face mask, maintain distance while talk, sneeze, cough and do not contact closely with the smoker immediately after smoke at least for 10 minutes . The government of India has taken a step to protect the passive smoking by introducing a smoking ban on March 29th 2004 .[12]

Poornima K.S. et al in their study Parental Perceptions towards Passive Smoking : A Cross-sectional survey in Vikarabad town, India explored environmental tobacco smoke is a known human carcinogen and passive smoking has now emerged as a health threat . Home is the major source of exposure to tobacco smoke among children . To explore parents' smoking behavior and their perception towards passive smoking and its effects on their children . 32 % reported they did not know smoking caused cancer and only 25 % strongly believed that if parents smoked , it had a harmful effect on children's health. Low education , unskilled job and a past experience of smoking related health problems have an influence on the way passive smoke and its harmful effects are perceived by smoking parents.[13]

Dodge R. in his study The Effects of Indoor Pollution on Arizona Children reported many studies and statistical reports proved that there are many ill effects of passive smoking are common among children who have continuously exposed to tobacco smoke involuntarily and the investigator also found many children with smoking released diseases such as LBW, respiratory infections, allergic reactions and still birth. The most of the children who affected by smoking related disease are belongs to the family with smoking father. [14]

Lindsay R.P. et al in their study The Association between Active and Passive Smoking and Latent Tuberculosis infection in Adults and Children in the United States : Result from NHANES sought to determine the association between active and passive smoking and LTBI is a representative sample of US adults and children. Active adult smokers and both foreign-born active and passive smokers in the United States are at elevated risk for LTBI. Targeted smoking prevention and cessation programme should be included in comprehensive national and international TB control efforts.[15]

Charlton A. in his study Children's coughs related to parental smoking made a survey on the smoking habits , attitudes and background of over 15000 8-19 year old in northern England in December 1982 showed a positive correlation between parental smoking and the reporting of frequent coughs by children who had never smoked. This was especially pronounced in the younger children.

Fewer older children in general reported frequent coughs. Mothers' smoking had more influence on children's coughs than had father's smoking. These results are clear evidence of a definite link between smoking in the home and coughs in young children, which not only may present immediate problems but may also be a cause of illness in the future.[16]

Mishra S., et al in their Second-Hand Smoke in a University Campus : Attitudes and Perceptions of Faculty, Staff and Students examine the attitude and perceptions of faculty, staff and students concerning tobacco policies at a university campus in a tobacco producing state. A questionnaire was to faculty, staff and students to assess knowledge, attitude and beliefs related to smoking and exposure to second-hand smoke on campus. Implementing a smoke free policy in university campuses in North America could be acceptable to faculty, staff and students and is unlikely to reduce students enrolment. Our findings have the potential to support efforts to implement smoke free policies on university campuses in North America. [17]

Pilkington P.A. et al in their study Attitudes towards Second Hand Smoke amongst a highly exposed workforce : Survey of London Casino Workers examine the knowledge, attitudes and experiences of London casino workers regarding exposure to second hand smoke (SHS) in the workplace. The majority of the responders are bothered by SHS, and many are concerned about the health impacts. Most want all working areas in their casino to be smoke free. Despite difficulties in generalizing from this limited sample, this findings add weight to the argument that the legislation on smoking in public places in England should encompass all workplaces, without exemption.[18]

Jarvis M.J et al in their study Children's exposure to passive smoking in England since the 1980s : Cotinine evidence from population surveys showed the past decade has seen increasing restrictions on smoking in public places. Much of the public health burden from passive smoking falls on children in the home, with clear evidence of causal effects for several diseases. The impact of this on children's measured exposure has not been established. We consider concentration in children with non-smoking parents as an indicator of influences from broad trend in society, and we examine whether there is evidence for a decline in exposure among children with smoking parents.[19]

Gately and Iain in their study said that as national cancer institute reported passive smoking results 10,000 LBW birth in every year and increases infant mortality rate and if the smoking pattern continue may cause some 10 million deaths in each year by 2020. Creating awareness to the smokers and the nonsmokers regarding ill-effects of passive smoking on the risk groups especially on children are essential to improve the health status of our country by reducing mortality and morbidity rates. The nurses can given health education to public regarding prevention of smoking related diseases, control measures of air pollution, ill effects of tobacco smokes and prevention of respiratory diseases in order to control the number of the smokers .[20]

All the above mentioned information are showing that ill-effects of passive smoking on children is a burning issues of the present days that parents of under five children need to know about its adverse effects to upcoming future of their children. But the parents of under five children are not having enough knowledge to provide proper protection of their children from ill-effects of passive smoking on children. So a planned teaching programme is necessary to enhance their knowledge regarding ill-effects of passive smoking on children.

So, the researcher was motivated to provide education to the parents who have smoking habits and have under five years children through planned teaching programme on knowledge regarding ill-effects of passive smoking on children.

C. Problem Statement

"Effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children among parents of under five years children of a selected rural community of south 24 parganas, West Bengal"

D. General Objective

To develop and find out the effect of planned teaching program on knowledge regarding ill-effects of passive smoking on children among parents of under five years children.

E. Specific Objectives

1) To develop and validate planned teaching program on knowledge regarding ill-effects of passive smoking on children among parents of under five years children.

2) To assess the knowledge regarding ill-effects of passive smoking on children among parents of under five years children before and after administration of planned teaching programme.

3) To determine the effect of planned teaching programme regarding ill-effects of passive smoking on children in terms of change in knowledge among parents of under five years children.

4) To find out the association between the pretest knowledge score regarding ill-effects of passive smoking on children among parents of under five years children and selected variables.

F. Hypothesis

H_1: After exposure to planned teaching programme regarding ill-effects of passive smoking on children the mean post test knowledge score of parents having under five years children is different than that of mean pretest knowledge score at 0.05 level of significance.

H_2: There is significant association between the pretest knowledge score on ill-effects of passive smoking on children and selected variables at 0.05level of significance.

Conceptual framework

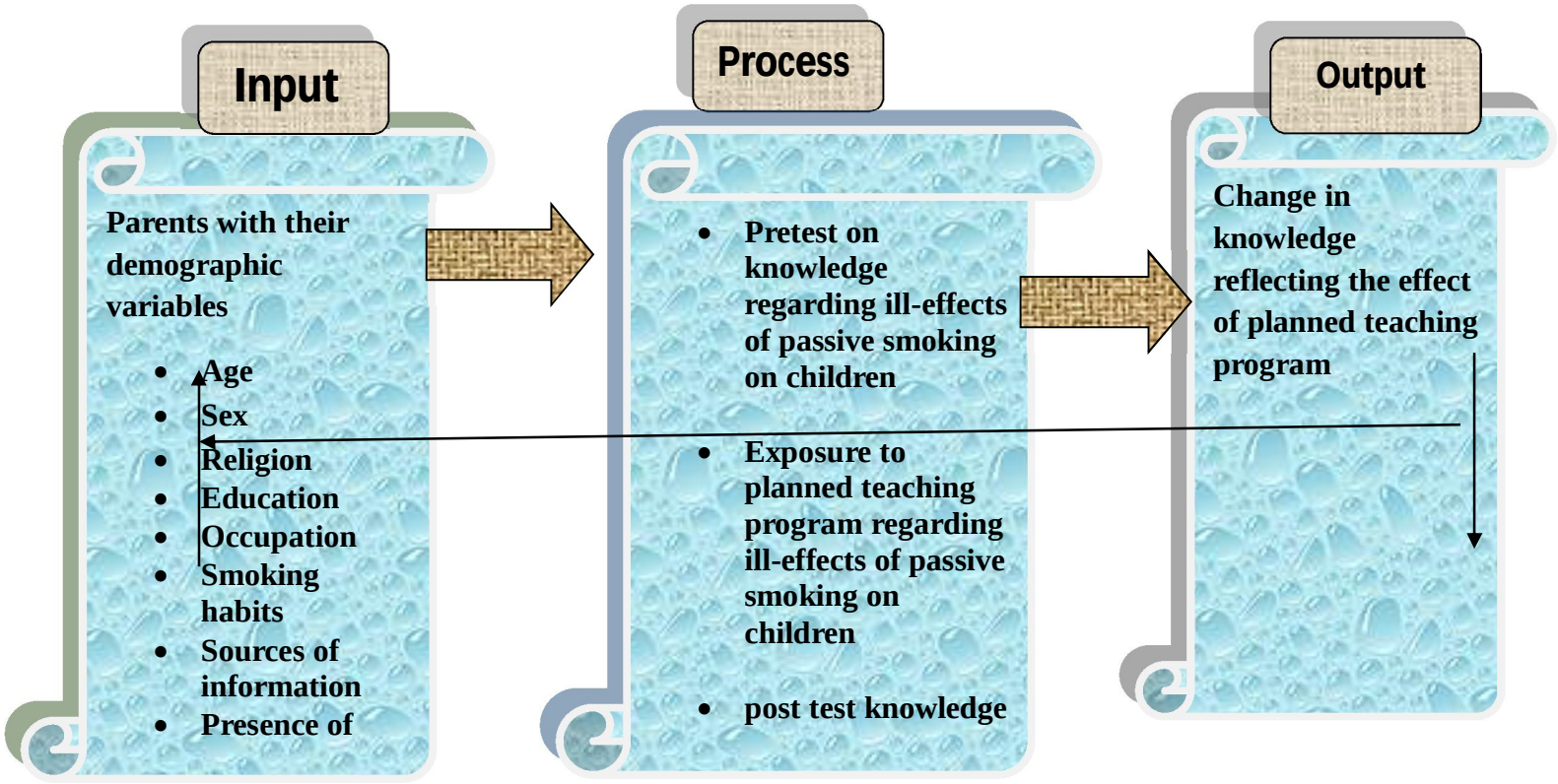


Figure 1 : Conceptual Frame Work based on Karl Ludwig Von Bertalanffy General System Theory

II. REVIEW OF LITERATURE

Literature review is a key step in research process and is defined as a broad comprehensive study, in-depth, systematic and critical review of scholarly publications, unpublished materials, audiovisual materials and personal communications.

According to Polit and Beck (2008), Review of Literature is defined as a critical summery of research on a topic of interest, often prepared to put a research problem in contact.

The Review of Literature has been organized and presented under the following sections :

- Studies related to prevalence of passive smoking.
- Review related parents' knowledge regarding passive smoking.
- Studies related to effect of the planned teaching programme regarding ill-effects of passive smoking.

A. Studies Related to Prevalence of Passive Smoking

Fernando D., Martinez, et al., conducted a type of study, on Increased Incidence of Asthma in Children of Smoking Mothers shows that the relationship between parental smoking and subsequent development of asthma and subsequent lung function (before age 12) study was conducted on more than 700 children enrolled before age of 5. Children of mothers with 12 or fewer years of education and who smoked 10 or more cigarettes per day were 2.5 times more likely (95% confidence interval 1.42 to 4.59; $P = .0018$) to develop asthma and had 15.7% lower maximal midexpiratory flow ($P < .001$) than children of mothers with the same relationships were independent of self-reported respiratory symptoms in parents. It is concluded that children of lower socioeconomic status may be at considerable risk of developing asthma if their mothers smoke 10 or more cigarettes per day. It is speculated that recently reported increases in prevalence of childhood asthma may be in part related to the increased prevalence of smoking among less educated women.[4]

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Reardon J., mention in his study, Environmental Tobacco Smoke Respiratory and other health effects shows that in children, Environmental Tobacco Smoke (ETS) is associated with an increased risk of lower respiratory tract infections(LRTIs),suchas bronchitis and pneumonia. An estimated 150,000-300,000 cases of LRTIs in children younger than 18 months are attributed to ETS annually. ETS is causally associated with increased prevalence of fluid in the middle ear, upper respiratory tract irritation, and reduced lung function. It is also associated with increased severity of asthma in children; the asthma of an estimated 200,000-1,000,000 children is worsened by ETS. Finally, ETS is a risk factor for the development of asthma in children.[21]

Jane Z and Ji B.T., mention in his study, Paternal Cigarette Smoking and the Risk of Childhood Cancer Among Offspring of Nonsmoking Mothers cigarette smoking has been shown to increase oxidative DNA damage in human sperm cells. We investigated the relationship of parental smoking, particularly in the preconception period, with childhood cancer among offspring of the non smoking mothers. We conducted a population based case-control study in Shanghai, People's republic of China, where the prevalence of smoking is high among men but extremely low among women.[22]

Janson C., mention in his study The Effect of Passive Smoking on Respiratory Health in Children and Adults that passive smoking or environmental tobacco smoke (ETS), has to be found to be casually associated with a large number of diseases in various organs although the evidence is sometimes conflicting . Legislative measures banning smoking at work have positive health effects in non-smokers and increase the quitting rate in smokers . Measures aimed at reducing childhood exposure to ETS should have high priority. Smoke cessation programs for pregnant women attending antenatal clinics and for parents at the time of child hospitalization for respiratory illness seems to have a fairly high success rate. Passive smoking is a wide spread, important and avoidable risk factor for respiratory symptoms in both children and adults. Reducing passive smoking in the community will have large positive effect on respiratory health.[23]

Whincup. P.H. et al mention in their study Passive Smoking and Risk of Coronary Artery Disease and Stroke : Prospective Study with Cotinine Measurement that active cigarette smoking is a well established major preventable risk factor for coronary artery disease. Biomarkers of passive exposures to smoking , particularly cotinine concentration in non-smokers has been related to prevalent CHD and stroke in non-smokers. We have examined these associations in the British regional Heart study , a prospective study of cardiovascular disease in middle aged men, using retained baseline samples for retrospective measurement of cotinine. [24]

Strachan D.P. Jarvis M.J. and Feyerabend C. mention in their study Passive Smoking , Salivary Cotinine Concentrations, and Middle Ear Effussion in 7 year old Children to assess the contribution of passive exposure to tobacco smoke to the development of middle ear under pressure and effusion .Cross sectional observational study and 1/3 of the primary schools in Edinburgh . 892 children aged 6 to 7 were examined and satisfactory tympanograms were obtained in 872. Results of assay of salivary cotinine concentrations were available for 770 children and satisfactory tympanograms were available for 736 of these. Corelation of the prevalence of middle ear under pressure and effusion with concentrations of the marker of nicotine, cotinine in the saliva of the children. The results of this study are consistent with those of case control studies of children attending for an operation to relieve middle ear effusion. They indicate that the disease should be added to the list of recognized hazards associated with passive smoking. About 1/3 of the cases of middle ear effusion in this study were statistically attributable to exposure to tobacco smoke. [25]

B. Studies Related to Parents' Knowledge Regarding Passive Smoking

Saldanha M.S.J. et al., conducted a descriptive study regarding Knowledge of Mothers on the effect of Passive Smoking in Children in a selected Hospital at Mangalore show that indirect exposure, also referred to as passive smoking, or involuntary smoking, or side stream smoke has been realized as a source of indoor air pollution that can harm non- smokers. These studies revealed that children of smoking parents have increased incidence of upper respiratory tract infections. A descriptive approach was adopted for this study. The sample consisted of 100 mothers who were selected by purposive sampling technique. Majority of the mothers (70%) had good knowledge, 28% had average knowledge, 1% had excellent knowledge and 1% had poor knowledge regarding effects of passive smoking in children. There was a significant association found between the knowledge and occupation of the mothers at $p< 0.05$ level of significance.The findings of the study have shown that the knowledge level of mothers was good (70%). The awareness campaigns and public awareness programs help in building knowledge; although ongoing programs and reinforcement about complications and dangers should be undertaken to sustain the knowledge and awareness among the mothers. [26]

Fabiane Alves de Carvalho Ribeiro et al. conducted a study regarding Perception of parents about second hand smoke on the health of their children show the understanding of the parents who were active smokers in relation to environmental tobacco smoke (ETS) and secondhand smoking.58 % with an average time of smoking of 15.3 years and an average quantity of cigarettes smoked per day of 2 were interviewed.

Among them, 59% did not know what ETS was, and 60% stated knowing what a secondhand smoker was. However, when questioned about their children as secondhand smokers, 52% did not consider them to be. Some parents knew some of the effects of secondhand smoking in the health of their children. However, the majority (52%) of them did not believe that their children would suffer any respiratory impairment or did not know about these impairments.Children were exposed to environmental tobacco pollution in their residence if one considers parental duration of smoking and average of cigarettes smoked per day. There was a lack of knowledge of the parents about ETS, second hand smoking and the evils that cigarettes could cause in the health of their children.[27]

Gharaibeh H., et al in their study Knowledge, Attitudes and Behaviour in Avoiding Second hand Smoke Exposure Among Non-smoking Employed women with Higher Education in Jordan showed that secondhand smoke (SHS) exposure is a serious public health threat worldwide; in the developing world there are less serious efforts towards controlling women's and children's exposure to SHS. Knowledge, attitudes and avoidance practices among Jordanian women have never been thoroughly studied. The purpose of this study was to assess the knowledge, attitudes, and avoidance behavior towards SHS exposure among employed Jordanian women with higher education.Most respondents were regularly exposed to SHS in various locations during daily life, even though they were very knowledgeable about the dangers of SHS exposure for women and children. However, the subject's attitudes and avoidance behavior did not reflect the level of knowledge about SHS risks. The results suggests there is a large discrepancy between SHS exposure, knowledge, attitudes and avoidance behavior among highly educated Jordanian women that is likely influenced by culture and traditional gender roles. Public health initiatives are needed in Jordan to address public policy, institutional practices and to empowerment of women to reduce SHS exposure.[28]

Margot E , Kurtz , Uche Azikiwe , C. Kurtz, in their study,Nigerian urban married women's perceptions of exposure to secondary tobacco smoke show that urban, married Nigerian women's knowledge of the health risks associated with secondary tobacco smoke, their attitudes toward this problem, and the preventive efforts they took when they or their children were exposed involuntarily to secondary tobacco smoke. Two hundred forty-nine women were surveyed with a structured, written questionnaire. The results indicated that these predominantly well-educated and professionally employed Nigerian women had only a fair knowledge of the adverse health effects of exposure to secondary tobacco smoke. [29]

C. Studies Related to Effects of Planned Teaching Programme on ill Effects of Passive Smoking

Philip,Phinse Mappalakayil et al. mentioned in their cross sectional survey approach regarding Evaluation of a Specially Designed Tobacco Control Program to Reduce Tobacco Use among School Children in Kerala shows that was conducted using a structured questionnaire in 13 randomly selected schools in Kannur district of Kerala. These students were followed for a period of one academic year with multiple spaced interventions such as anti-tobacco awareness classes, formation of anti-tobacco task forces, inter-school competitions, supplying IEC (information, education and communication) materials and providing a handbook on tobacco control for school personnel. The prevalence of tobacco smoking and chewing habits were 9.85% and 2.24% respectively. Ninety-one percent had parental advice against tobacco use and only 3.79% expressed desire for future tobacco use. The final evaluation witnessed a sharp decline in the current tobacco use as 4.68%. We observed a statistically significant difference towards the future use of tobacco ($p<0.001$) and awareness about the ill effects of passive smoking ($p<0.001$) among boys and girls. Further a significantly increased knowledge was observed among boys compared to girls about tobacco and oral cancer ($p=0.046$). [30]

Verma A. et al, in their study Exploring an Effective Tobacco Prevention Programme for Indian Adolescents presented that school-based smoking prevention programmes have been shown to increase knowledge about the negative effects of tobacco and prevent tobacco use. This study investigated the impact of a school-based short-term educational intervention regarding tobacco use on adolescents' knowledge, attitudes, intentions and behaviours (KAIB) in Bangalore, India. Educational interventions were imparted to all study subjects in a phased manner, along with two interactive sessions held six months apart. Mean (±standard deviation) pre-intervention KAIB scores of the subjects were 5.9 ± 1.87 (knowledge), 23.6 ± 3.15 (attitude) and 18.9 ± 3.27 (practice), which improved to 7.8 ± 2.01, 26.7 ± 2.43 and 12.3 ± 2.52, respectively, post intervention. The differences in mean KAIB scores were significant ($P < 0.0001$, $df = 1400$), suggesting that the intervention had a major positive impact. School-based short-term educational intervention programmes are effective for preventing and reducing tobacco use among Indian adolescents.[31]

Isensee B. et al in their study Effects of a School-based Prevention Programme on Smoking in early adolescence : a 6month follow –up of the 'Eigenstanding Werden' Cluster randomized trial tested the effects of a school-based prevention programme on students' smoking-related behaviour, attitudes and knowledge 6 months after implementation over 2 school-years has ended. Analysis sample with follow-up up data merged to baseline data comprises 2513 datasets (73%).

'Eigenständig werden 5+6', a school-based prevention programme for grades 5 and 6 to enhance substance-specific and general life skills, consisting of 14 units (à 90 min) and two workshops (4–6 h) being taught over a time period of 2 school-years by trained teachers. Lifetime and current smoking, incidence of smoking in baseline never smokers, smoking-related knowledge, attitudes, perceived norms of smoking and self-efficacy to refuse cigarette offers were assessed in students. 6 months after the end of programme implementation, students of intervention classes showed significantly lower rates for lifetime smoking (adjusted OR=0.63; 95% CI 0.41 to 0.96; p=0.026) and incidence of smoking (adjusted OR=0.66; 95% CI 0.43 to 1.00; p=0.047), a higher increase of smoking-related knowledge (adjusted β=9.38; 95% CI 6.73 to 12.04; p<0.001) and a greater change in attitudes towards a more critical perception of risks and disadvantages of smoking (adjusted β=0.10; 95% CI 0.03 to 0.16; p=0.002). No group differences were found for current smoking, perceived norms of smoking and self-efficacy to refuse cigarette offers.[32]

Irvine L., et al conducted a study, Advising Parents of Asthmatic Children on Passive Smoking : Randomized Control Trial to investigate whether parents of asthmatic children would stop smoking or alter their smoking habits to protect their children from environmental tobacco smoke. The design of the study is randomized controlled trial. Setting is Tayside and Fife, Scotland . Participants are 501 families with an asthmatic child aged 2-12 years living with a parent who smoked . However there was a non significant tendency for parents in the intervention group to report smoking more both at follow up and to having a reduced desire to stop smoking. A brief intervention to advise parents of asthmatic children about the risk from passive smoking was ineffective in reducing their children's exposure to environmental tobacco smoke. The intervention may have made some parents less inclined to stop smoking . If a clinician believes that a child's health is being affected by parental smoking, the parent's smoking needs to be addressed as a separate issue from the child's death. [33]

Akhtar P.C., et al conducted a study, Changes in Child Exposure to Environmental Tobacco Smoke (CHETS) study after implementation of smoke-free legislation in Scotland : National cross sectional survey to detect any change in exposure to second hand smoke among primary school children after implementation of smoke free legislation in Scotland in March 2006. Comparison of nationally representative , cross sectional, class based surveys carried out in the same schools before and after legislation . Little change occurred in reported exposure to Scotland smoke in pupils' own homes or in cars, but a small decrease in exposure in other people's homes was reported . Pupils reported lower exposures in cafes and restaurants and in public transport after legislation . The Scottish smoke-free legislation has reduced exposure to Scotland smoke among young people in Scotland , particularly among groups with lower exposure in the home . We found no evidence of increased second hand smoke exposure in young people associated with displacement of parental smoking into the home. The Scottish smoke-free legislation has thus had a positive short term impact on young people's health, but further efforts are needed to promote both smoke-free homes and smoking cessation. [34]

III. METHODOLOGY

The methodology of research indicates the general pattern for organizing the procedures for gathering valid and reliable data for the study . The research methodology includes the strategies to be used to collect and analyze the data to accomplish the research objectives and to test the research hypothesis. The present chapter provides a brief description of the different steps taken to conduct the study . It includes the research approach, research design, the sample and sampling technique, development and description of tools, information booklet, pilot study and procedure of data collection and plan of data analysis.

This study was aimed at assessing " Effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children among parents of under five years children of a selected rural community of south 24 parganas, West Bengal"

A. Research Approach

In this study the Pre-experimental research approach was considered to be the best approach.

B. Research design

Research design is overall plan or blueprint for addressing a research question, including specifications, for enhancing the study integrity. In this study, the research design used was one group pre test post test design.

A symbolic representation given below

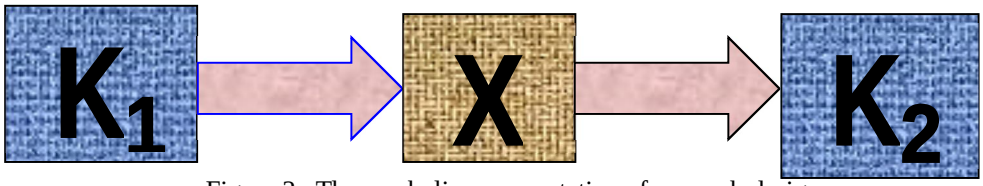


Figure 2 : The symbolic representation of research design

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Interpretation of symbols are as follows :

K: Assessment of pretest knowledge of parents of under five years children regarding ill-effects of passive smoking on children by administering structured interview schedule on knowledge on 1st day.

X: Administration of planned teaching programme regarding ill-effects of passive smoking on children to parents of under five years children on 1st day.

K2: Assessment of post test knowledge of parents of under five years children regarding ill-effects of passive smoking on children by administering same structured interview schedule on knowledge on 8th day.

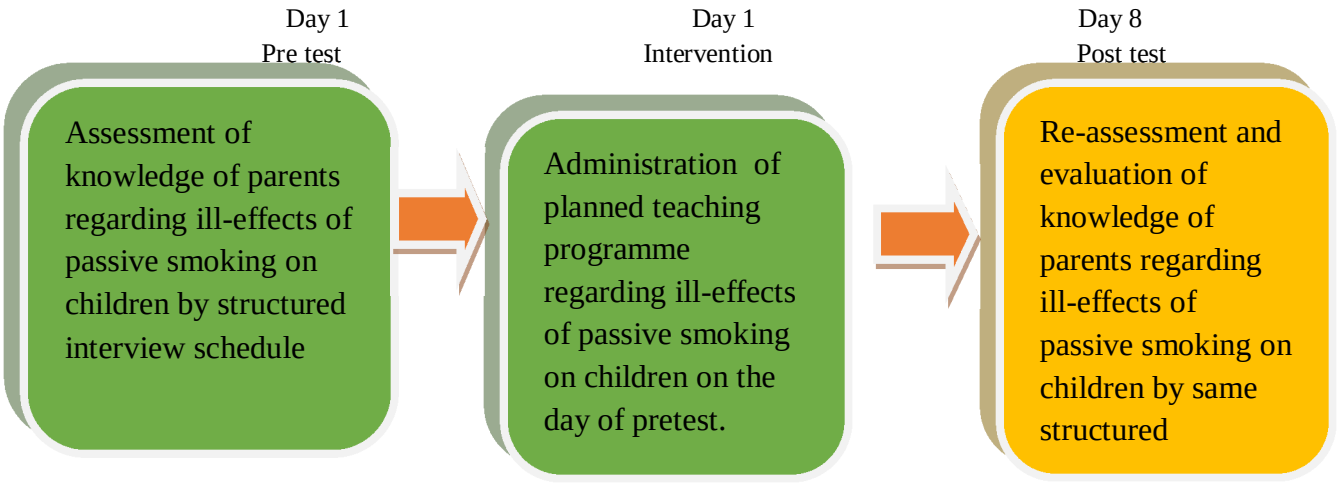


Figure 3 : Schematic presentation of the research design Setting of the study

Setting is the physical location and conditions in which data collection takes place. It is important to select an appropriate setting as the nature of the setting can influence the way people behave or feel and how they respond to questions.

The pilot study was conducted at Muragacha village under Kalikapur PHC, Sonarpur Rural hospital , Dist- south 24 parganas.

The final study was conducted at Poleghat village under Poleghat sub-centre under Sonarpur Rural Hospital, Dist-south 24 parganas.

Cause for selection of the community.

- Familiar with setting
- Availability of adequate sample
- Feasibility of conducting the study
- Easy to access
- Administrative approval
- Cooperation from all level of health personnel

C. Population

Population is the entire aggregate of subjects that meet a designated set of criteria. For this study the population consists of parents who have smoking habits and have under five years children.

D. Sample and sample size

Sample : In this study the sample are the parents who have smoking habits and have under five years children of selected village, south 24parganas.

Sample Size : Sample for the present study comprised of enumerated 60 parents who have smoking habits and have under five years children.

.Sampling technique

Sample are chosen by Non probability purposive sampling techniques.

Sample criteria

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Inclusion Criteria

- Parents who smoke and have under five years children.
- Parents who are available during the study.
- Parents who are willing to participate in the study.
- Parents who understand Bengali.
- Parents do not have any hearing and visual problem.

E. Data Collection Tool and Techniques

The following data collection tool was constructed in order to collect necessary information and presented in the following way.

Table-1 : Data collection tools, variables and techniques.

Tools	Data collection tool	Variables	Technique
1.	Interview schedule **Part-A** Semi-structured interview Schedule	Demographic data of parents of under five years children	Interviewing
	Part-B Structured interview Schedule	Knowledge regarding ill-effects of passive smoking on children	Interviewing

Table 2 : Result of the Content Validity

Tool	Content Validity	Result
Part A (Demographic Variables)	60 % agreement in question no 7,12 80% agreement in question no 2,3,5,10,14,15 100 % agreement in question no 1,4,6, 8,9,11,13	Question no 7,12 modified
Part B (Knowledge regarding ill-effects of passive smoking on children)	40 % agreement in question no 1 80 % agreement in question no 5,11,16, 17,18 100 % agreement in question no 2,3,4,6,7,8,9,10,12,13,14,15	Question no 1 discarded

Table 3: Calculation and results of the reliability testing

Name of the tool (Interview schedule)	Method of calculation of reliability	Result
Part A (Back ground information)	Rater-inter-rater percentage of agreement	100% agreement in all items
Part B (Knowledge regarding ill-effects of passive smoking on children)	Split half method and ‘r’ computed by Spearman brown proficiency formula	Reliability of the tool was 0.75. So the tool is highly reliable.

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F. Plan of Data Analysis

The data analysis was planned with the help of descriptive statistics and inferential statistics based on objectives and hypothesis of the study. The plan for data analysis is as follows :

Descriptive statistics used to describe :

1) Frequency and percentage distribution to describe demographic variables of the participants.

Inferential statistics used to describe :

a) Comparative bar diagram showing the frequency percentage distribution of pretest and post test knowledge score.

b) Area wise modified gain score to determine the significance of difference between pretest and post test mean percentage knowledge score in each area.

c) Mean, median and standard deviation and 't'value of pretest and post test knowledge score of the participants to determine the effect of the planned teaching programme.

d) Frequency polygon to compare pretest and post test knowledge score.

e) Chi-square for determine of the association between pretest knowledge score and selected demographic variables.

IV. ANALYSIS AND INTERPRETATION

The report of analysis and interpretations of the data were presented in the following table.

Table 4 : Organization and presentation of data

Objective of the study	Section	Description	Statistical Method
To identify the demographic characteristics of the parents of under five years children	I	Findings related to demographic characteristics of the parents of under five years children	Frequency and percentage distribution
To assess the knowledge of the parents of under five years children regarding ill-effects of passive smoking on children before and after exposure to the planned teaching programme	II	Findings related to comparison between pretest and post test knowledge of the parents of under five years children regarding ill-effects of passive smoking on children	Comparison between pretest and post test knowledge score Area wise mean % of knowledge score
To find out the effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children among parents of under five years children in relation to knowledge score	III	Findings related to effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children among parents of under five years children	Paired 't' test
To find out the association between pre test knowledge score of the parents of under five years children regarding ill-effects of passive smoking on children with selected variables	IV	Findings related to association between pretest knowledge score and the selected variables	Chi square

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1) Section I

This section describes the demographic characteristics of 60 participants in terms of their age, religion, types of family, number of under five years children in the family, education, occupation, per capita income, smoking habits, source of information regarding ill-effects of passive smoking and history of illness of under five years children in the family, previous knowledge regarding ill-effects of passive smoking on children.

Findings related to demographic characteristics of the parents of under five years children.

Table 5 : Frequency and percentage distribution of parents of under five years children in terms of their age, religion, types of family and number of under five years children of the family.

N=60

Sl No	Items	Frequency	Percentage (%)
1.	Age		
	• 18-23 yrs	8	13.33
	• > 23-29 yrs	27	45
	• > 29-35 yrs	16	26.67
	• > 35 yrs	9	15
2.	Religion		
	• Hindu	2	3.33
	• Muslim	58	96.67
3.	Types of family		
	• Joint family	31	51.67
	• Nuclear family	29	48.33
4.	No of under five children in the family		
	• One		
	• Two	52	86.67
	• ≥ Three	7	11.66
		1	1.66

Data presented in table 5 shows that 45 % parents were from age group between > 23-29 years age and 13.33 % parents were from age group between 18-23 years age.

96.67 % parents were Muslims and 3.33 % parents were Hindu.

51.67 % parents were from joint family and 48.33 % parents were from nuclear family. No extended family was present.

86.67 % families have one under five years children and 1.66 % families have three under five years children.

100 % of parents were from male category.

Table 6 : Frequency and percentage distribution of parents of under five years children in terms of education, occupation and per capita per month income of the family members.

N=60

Sl No	Items	Frequency	Percentage (%)
1.	Education		
	• Just Literate	11	18.33
	• Primary	25	41.66
	• Middle Secondary	17	28.33
	• Secondary	3	5
	• H.S.	2	3.33
	• > H.S.	2	3.33
2.	Occupation		
	• Farmer	1	1.66
	• Labor	24	40
	• Driver	23	38.33
	• Service	7	11.67
	• Business	5	8.33

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3.	Per Capita Income		
	• ≤ 2000/-	36	60
	• 2001-3000/-	17	28.33
	• 3001-4000/-	5	8.33
	• > 4000/-	2	3.33

Data presented in table 6 shows that 41.66 % parents had primary education
(Class I-IV), 3.33 % parents had higher secondary education and another 3.33 % parents had above higher secondary education.
40 % parents were labor and 1 % parent was farmer.
60 % families had Rs. ≤2000/- per capita per month income and 3.33 % families had Rs. > 4000/- per capita per month income.

N=60

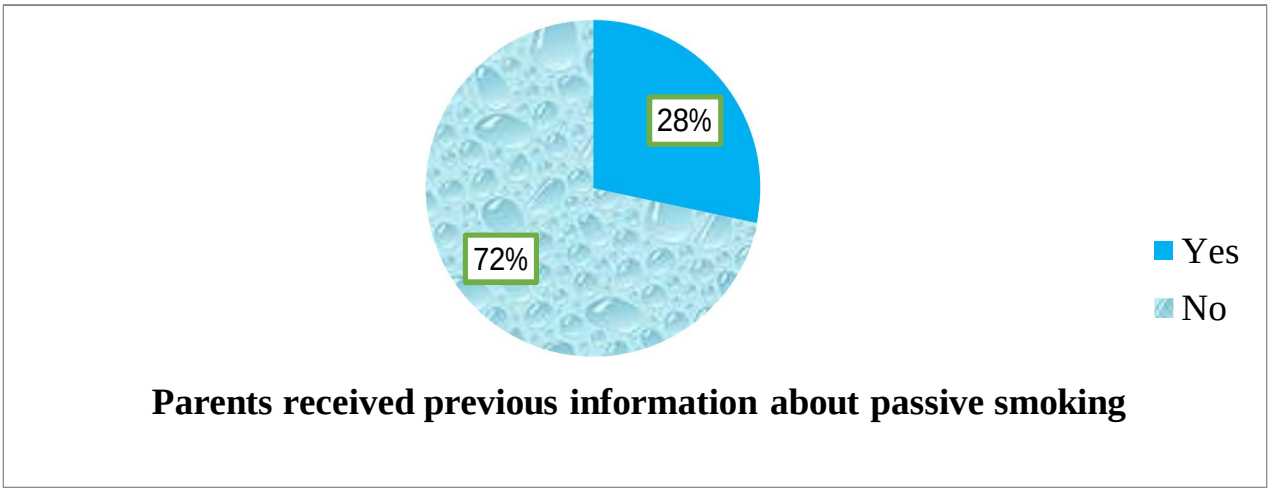


Figure 4 : Pie diagram of percentage distribution of parents according to the previous information about passive smoking.

Data depicted in figure 4 shows that 28.33% parents received information about passive smoking and 71.66 % parents didn't received any information about passive smoking.

n=17

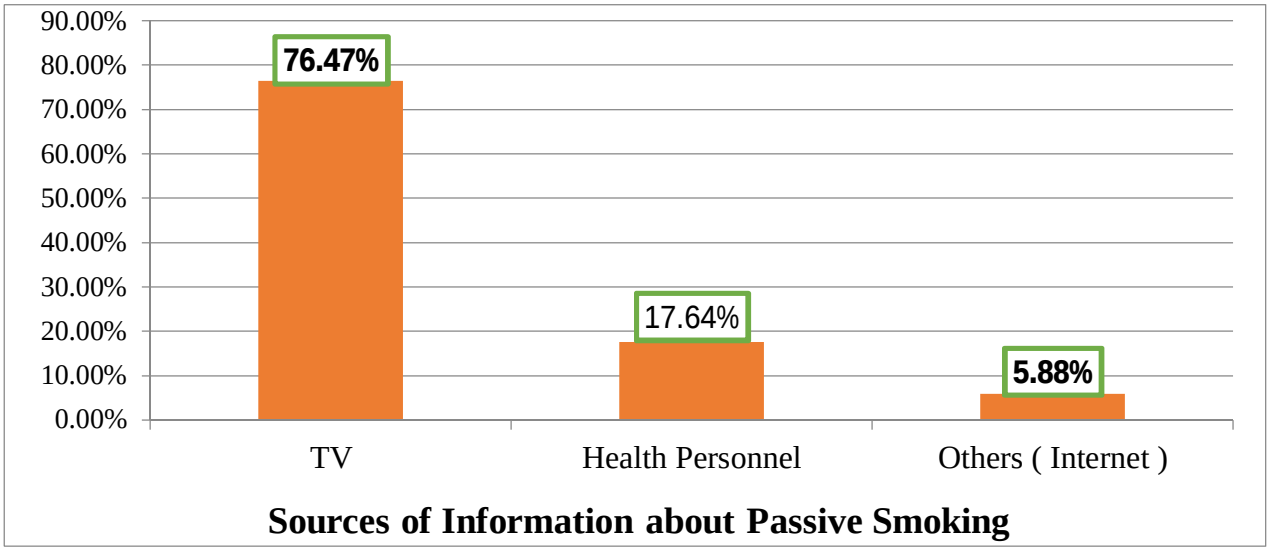


Figure 5 : Bar diagram of percentage distribution of parents on sources of information about passive smoking.

Data represented in figure 5 shows that 76.47 % parents received the information from the TV and 5.88% parent received the information from the others i.e. from internet .

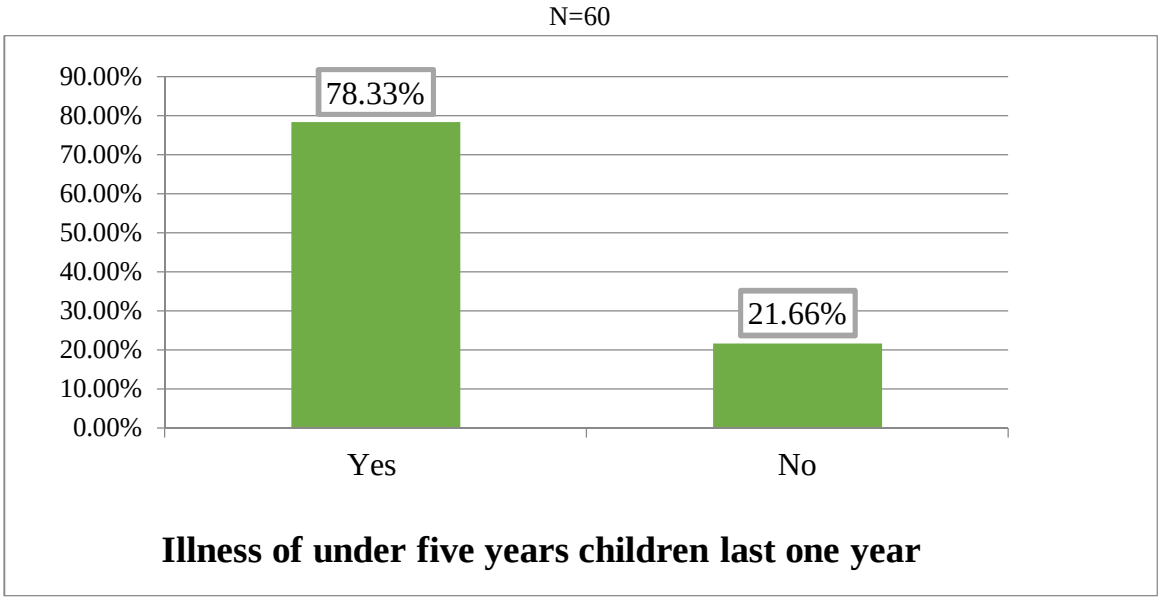


Figure 6: Bar diagram of percentage distribution of the illness of under five years children since last one year

Data presented in figure 6 shows that 78.33 % families children of under five years of age suffered from illness since last one year and 21.66 % children of under five years of age didn't suffer from illness. Among the children who have suffered from the illness mainly fever, diarrhea, breathing difficulties, measles, blood dysentery, worm infestation and oral infection etc.

Table 7 : Frequency and percentage distribution of demographic variables like in terms of age of first smoking, number of smoking per day, place of smoking, number of smokers in the family and smoking in front of the children .

N=60

Sl No	Items	Frequency	Percentage (%)
1.	Smoking starts at the age		
	• 13-17 yrs	11	18.33
	• 18-22 yrs	39	65
	• > 22-27 yrs	7	11.66
	• > 27-32 yrs	2	3.33
	• > 32-37 yrs	1	1.66
2.	Number of smoking per day		
	• 1-5 times	51	85
	• 6-10 times	4	6.66
	• 11-15 times	2	3.33
	• 16-20 times	2	3.33
	• 21-30 times	1	1.66
3.	Place of smoking		
	• Inside of the house	3	5
	• Outside of the house	22	36.66
	• Both	35	58.33
4.	No of smokers in the family		
	• One	35	58.33
	• Two	13	21.66
	• ≥Three	12	20
5.	Smoking in front of the children		
	• Always	7	11.66
	• Seldom	17	28.33
	• Often	2	3.33
	• Rare	9	15
	• Never	25	41.66

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Data depicts in table 7 shows that 65 % parents started their smoking habits between the age group of 18-22 years of age and 1.66 % parents started from the age group between > 32-37 years of age.
85 % parents smoked 1-5 times and 1.66 % parents smoked 21-30 times per day.
58.33 % parents smoked both inside and outside of the house and 5% parents smoked inside of the house.
58.33 % families had one smokers in the family and 20 % families had ≥ 3 smokers in the family.
41.66 % parents never smoked in front of their children and 3.33 % parents often smoked in front of their children .

2) Section II

Findings related to comparison between pre test and post test knowledge score of parents of under five years children regarding ill-effects of passive smoking on children.

a) Pre test and post test knowledge score of parents regarding ill-effects of passive smoking on children.

N=60

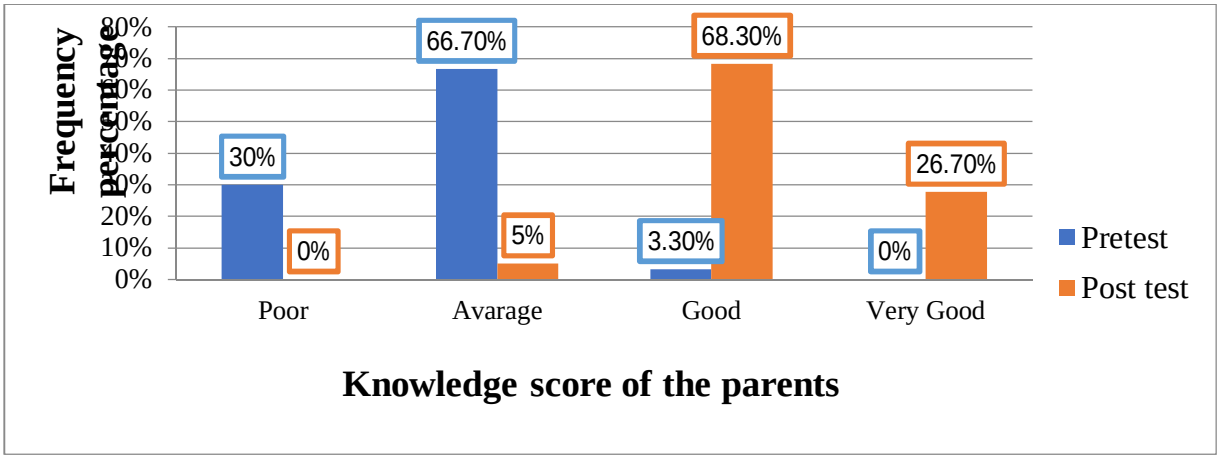


Figure 7 : Bar diagram shows frequency percentage of pretest and post test knowledge score of parents regarding ill-effects of passive smoking on children.

Data represented in figure 7 shows that in pre test 30 % parents have poor knowledge, 66.70 % parents have average knowledge, 3.30 % parents have good knowledge and no parent has very good knowledge.
In post test no parent has poor knowledge, 5 % parents have average knowledge, 68.30 % parents have good knowledge and 26.70 % parents have very good knowledge.
Findings related to assessment of pretest and post test knowledge score after exposure to planned teaching programme .

b) Area wise maximum possible gain score (%) and modified gain score on knowledge of the parents of under five years children regarding ill-effects of passive smoking on children.

Table 8 : Area wise modified gain score on knowledge of the parents regarding ill-effects of passive smoking on children.

N=60

Sl No.	Area of Knowledge	Maximum score	Mean % score		Mean % gain		Modified gain score
			Pretest	Post test	Actual	Possible	
1.	Meaning of passive smoking	2	80 %	99 %	19 %	20 %	0.95
2.	Vulnerable group	2	28 %	63 %	35 %	72 %	0.49

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3.	Contributing factors	3	19 %	62 %	43 %	81 %	0.53
4.	Sign and symptoms	1	65 %	83 %	18 %	35 %	0.51
5.	Treatment	1	22 %	87 %	65 %	78 %	0.83
6.	Prevention	5	18 %	51 %	33 %	82 %	0.40
7.	Precaution	2	17 %	57 %	40 %	82 %	0.48
8	Complication	2	30 %	48 %	18 %	70 %	0.26

Actual gain score % = Post test mean % score – Pre test mean % score
Possible gain score % = possible score-Pre test mean score % (possible score is 100)
Modified gain score = Actual gain score % / Possible gain score %
The data presented in table 8 shows that maximum knowledge gain as per modified gain score happen in area of meaning of passive smoking i.e 0.95. The table also shows that mean post test test percentage 99 % which was there was higher than mean pretest percentage of knowledge score i.e.80%.

3) Section III

Findings related to the evaluation of effect of planned teaching programme on knowledge regarding ill-effects of passive smoking on children among the parents of under five years children .
In order to describe the analysis, description and interpretation of the data collected to determine the knowledge of the parents regarding ill-effects of passive smoking n children.
In order to see the effect of planned teaching programme the following hypothesis were stated.
H_1: After exposure to planned teaching programme regarding ill-effects of passive smoking on children the mean post test knowledge score of parents having under five years children is different than that of mean pretest knowledge score at 0.05 level of significance.
To test the research hypothesis null hypothesis was formulated.
H_{01}: After exposure of planned teaching programme the mean post test of knowledge of parents of under five year children is found not different from that of mean pretest knowledge at 0.05 level of significance.

Table 9 : Mean, Median, Mean Difference, Standard Deviation Standard Error Mean Deviation & 't' value of pre test & post test knowledge score of the parents of under five years children regarding ill-effects of passive smoking on children.

N=60

Sl no	Knowledge score	Mean	Mean difference	Median	SD	S_EM_D	't' value
1.	Pre test	6.18	5.27	5	0.56	0.084	**9.06 ***
2.	Post test	11.45		12	0.36		

df (60) = 2.00, P<0.05

The data presented in table 9 shows that mean post test knowledge score 11.45 is significantly higher than mean pretest knowledge score 6.18 with a mean difference 5.27 which is found to be statistically significant as evident from 't' value 9.06 for df 60 at 0.05 level of significance.

This shows that the obtained mean difference between pretest & post test knowledge score is a true difference not by chance. The data also represents that the SD of pretest knowledge score 0.56 is higher than the Sd of the post test knowledge score o.36 of parents of under five years children. It indicates that the post test knowledge was more homogenous than the pretest knowledge score. Computed't' value between pretest & post test knowledge score is 9.06 at df 60 is more than tabulated value t(60) = 2.00 . So research hypothesis is accepted and the null hypothesis is rejected which implies the effectiveness of the planned teaching programme regarding ill-ffects of passive smoking on children.

For further elucidation, pretest and post test knowledge score of parents of under five years children are plotted in a frequency polygon.

Frequency polygon was plotted to find out the significant difference between pretest and post test mean knowledge score.

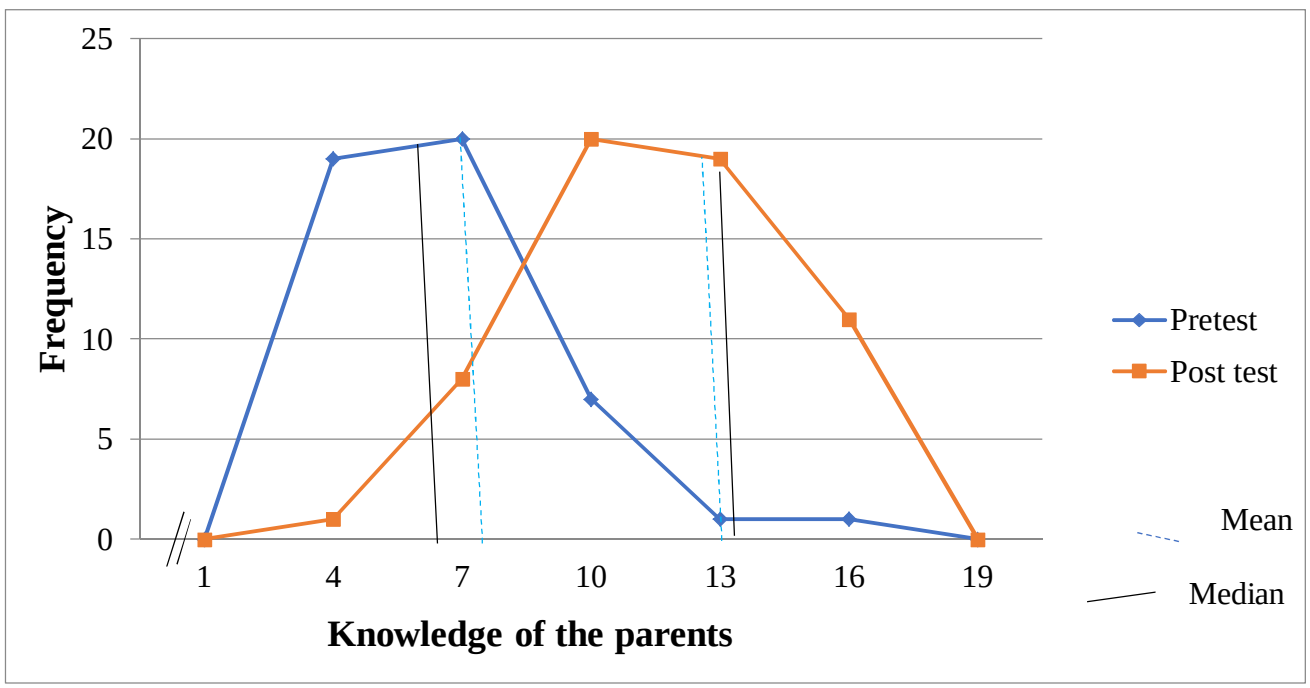


Figure 8 : frequency polygon for comparison between pretest and post test knowledge score of parents regarding ill-effects of passive smoking.

The frequency polygon depicted in the figure number 8 shows the distribution of pretest and post test knowledge score of parents regarding ill-effects of passive smoking on children with depiction of mean and median. The pretest knowledge score of the parents ranged from 3-12, with mean 6.18 and median 5. Maximum frequency 19 lied in the class interval of 4-6. The post test knowledge score of the parents ranged from7-14, with mean 11.45 and median 12. Maximum frequency 20 lied in the class interval of 10-12. The frequency polygon depicted that the post test knowledge score of the parents fall beyond the of the pretest knowledge score. In the pretest knowledge score mean laid right side of the median. So, the distribution was positively skewed and skewness was 2.11. In post test the mean lied left side of the median. So the distribution was negatively skewed and skewness was 19.81which indicates that scores are normally distributed.

4) Section IV

Findings related to the association between pre test knowledge score & selected variables.

This section described the description, analysis & interpretation of findings related to association between participants pretest knowledge score & selected demographic variables. The following hypothesis was stated—

H2: There is significant association between pretest knowledge score & selected demographic variables at 0.05 level of significance.

H02: There is no significant association between pretest knowledge score & selected demographic variables at 0.05 level of significance.

Table 10 : Chi square value & their association between the pretest knowledge score & demographic variables of the parents like age, education and previous exposure to information about passive smoking on children and years of smoking habits.

N=60

Sl No	Variables	Below median	Median and Above median	Df	Chi-square value	'p' value of 0.05 level
1.	Age					
	• 18-23yrs	3	5			
	• 24-29yrs	8	19			
	• 30-35yrs	4	12	3	0.46	7.82
	• >35yrs	3	6			
2.	Education					
	• Just Literate	2	9			
	• Primary	7	18			
	• Middle	7	10	3	1.79	7.82
	• Secondary & Above	2	5			
3.	Previous exposure to information about passive smoking					
	• Yes	5	12	1	0.003	3.84
	• No	13	30			
4.	Years of smoking					
	• 2-5 years	3	6			
	• 6-9 years	7	19	6	4.73	12.59
	• 10-13 years	5	9			
	• 14- ≥ 26 years	4	7			

The data represented in the table 10 shows that the tabulated X^2 value is greater than the calculated X^2 value in case of demographic variables like age, education and previous exposure to information about passive smoking on children and years of smoking of the parents. So there are no significant association between pre test knowledge score with selected demographic variables like age, education and previous exposure to information about passive smoking on children and years of smoking of parents. Hence research hypothesis is rejected and null hypothesis is accepted.

V. DISCUSSION

This chapter dealt with the major findings related to the study, discussion in relation with the findings of the other study , conclusions and implications of the study in nursing education, nursing service, nursing administration and nursing research. The limitation of the study had also been articulated in this section and investigator had attempted to give account of suggestions and recommendation for further study field of nursing.

Discussion

Present Study	Related Other studies
In present study in pretest 30 % parents had poor knowledge and 66.70 % had average knowledge . In post test 5 % parents had average, 68.30 % had good and 26.70 % parents had very good knowledge.	Kausturi V.K. in his study showed that pre-test 91.66 % students had poor and 8.33 % had moderate knowledge.[35] In post-test 33.33 % students had adequate, 56.66 % had moderate and 10 % had inadequate knowledge levels.

Pretest mean and SD score were 6.18 & 0.56 Post test mean & SD scores were 11.45 & 0.36. The present study showed that 30% (18) out of 60 parents were having poor level of knowledge, 66.70 % (40) had average knowledge. Remaining 3.30 % (2) parents had moderate knowledge and o% had good knowledge category. So, the result proven that there was no association between pre test knowledge score with the selected demographic variable.	Pre-test mean & SD scores were 30.54 & 11.235. post-test means & SD scores were 68.6 & 12.068. Thomas G.H. in her study showed that the majority 43%(43) out of 100 adolescents were having poor level of knowledge. Regarding remaining 57% (57) adolescents had average level of knowledge and o% had good knowledge category. [36] So, the result proven that there was an association between pre test knowledge score with the selected demographic variables.

VI. CONCLUSION

The following conclusion was drawn on the basis of the study :

1) the planned teaching programme can be developed easily by the nursing personnel .
2) It is effective to enhance knowledge of the parents and also easily accessible to them.
3) This planned teaching programme is a good reference to develop understanding of the parents to retain memory for learning easily.
4) The parents have accepted the planned teaching programme.

A. Implication

The findings of the study has an implication to nursing service, nursing education, nursing administration, nursing practice and nursing research.

B. Nursing Education

Education is the key component in improving the knowledge of an individual.

1) The present study shows that the planned teaching programme regarding ill-effects of passive smoking on children is effective to increase the knowledge of the parents. Therefore it can be effectively used by nursing educators to educate nursing students, nursing personnel, community people.
2) Nurse educators can give information to student nurses regarding ill-effects of passive smoking on children, so that nurses can apply it in the practical field when required and as community health nurses can give health teaching to improve knowledge of the parents.

C. Nursing Administration

1) Findings of this study will help the nurse administrators to develop the planned teaching programme regarding ill-effects of passive smoking on children .
2) The nurse administrators can arrange in-service education class, workshop, seminar on this topic to improve knowledge regarding ill-effects of passive smoking on children.
3) Nurse educators need to organize a continued nursing education programme beneficial to the hospital and the community.

D. Nursing Service

Nursing students can gain knowledge regarding ill-effects of passive smoking on children. She should take an important and active role in educating the parents of the children .

E. Nursing Research

Nursing personnel working in the hospital and the community can do further research on effectiveness of the planned teaching programme regarding ill-effects of passive smoking on children. Other study design can be adopted as comparative study between planned teaching and video based teaching programme.

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F. Limitation

The limitation of the study findings are :

1) The findings can not be generalized as it was conducted only in rural community.
2) Non-probability purposive sampling technique was used, so the scope for generalization is less.
3) Limited sample size (60) restricts the findings to be generalized.
4) Knowledge of the parents of the urban community can not be assessed as it is limited to rural community only.
5) Mothers who have smoking habits are not found during the study.

VII. ACKNOWLEDGEMENT

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The researcher appreciates the authority of Swastha Bhawan , Kolkata for giving her permission to conduct the pilot study in Muragacha village . She expresses her gratitude to the C.M.O.H. of south 24 Parganas and B.M.O.H. (Sonarpur Rural Hospital) for their co-operation making it possible to conduct and complete the study. Researcher is thankful to the authority of Swastha Bhawan , Kolkata for giving permission to conduct the final study in Poleghat village . She expresses her gratitude to the C.M.O.H. of south 24 Parganas and B.M.O.H. (Sonarpur Rural Hospital) for their co-operation making it possible to conduct and complete the study.

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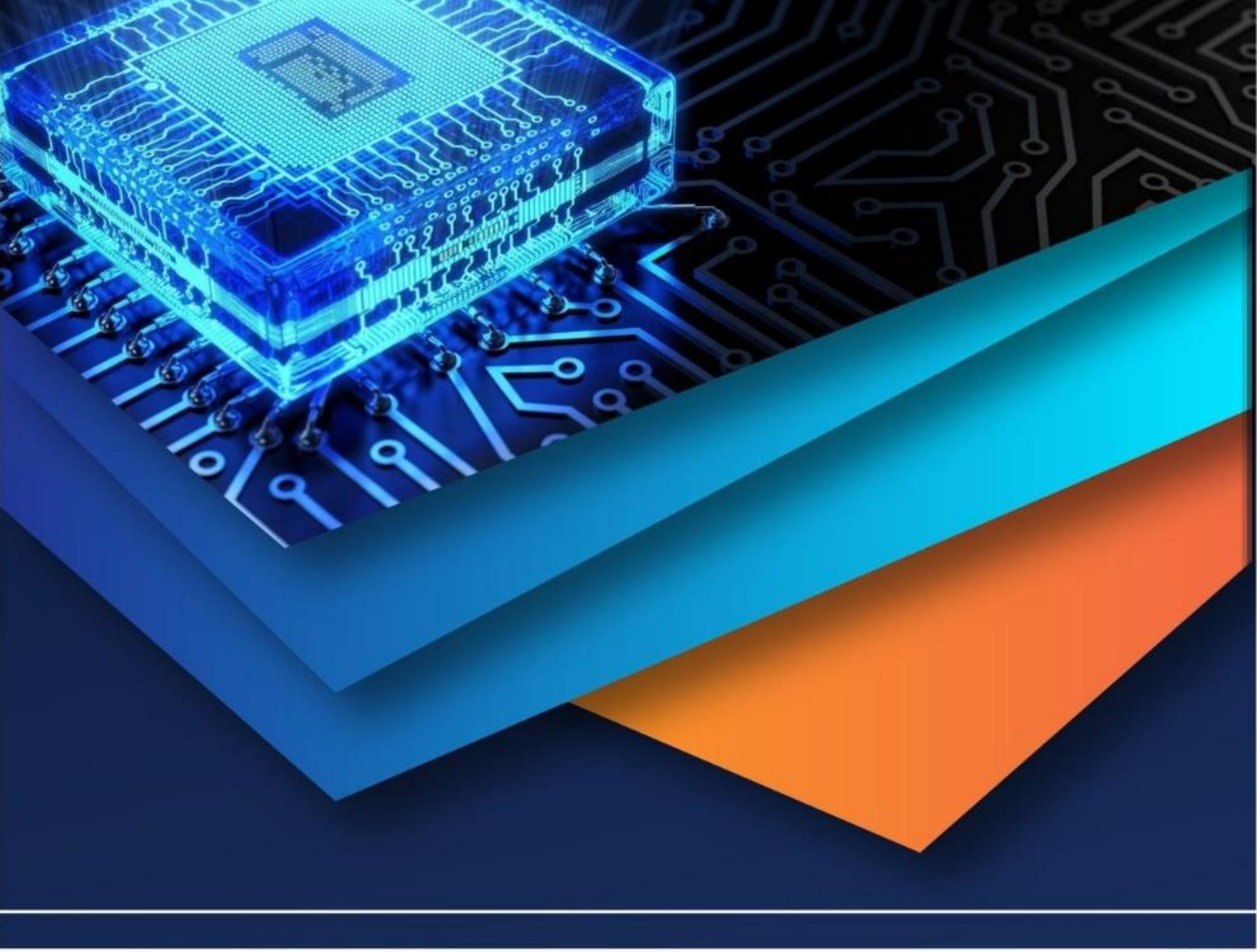
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