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A study to evaluate the effectiveness of video teaching programme on knowledge regarding hazards of open defecation among people in selectedslum area at Rajkot

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Abstract
A study to evaluate the effectiveness of video teaching programme on knowledge regarding hazards of open defecation among people in selected slum area at Rajkot. (a)The objectives of the study were to assess the existing level of Knowledge of slum people regarding hazards of open defecation. (b)To evaluate the effectiveness of a Video teaching programme on knowledge regarding hazards of open defecation in terms of Knowledge among slum people at Rajkot. (c)To find out the association between post-test level of knowledge regarding hazards of open defecation and their selected demographic variables.
The research approach selected for the study was quantitative research pre-experimental research design with one group pre and post-test design. The study conducted at selected colleges at Rajkot. Total 60 sample selected from selected slum area at Rajkot. setting based on probability and non-probability sampling. The researcher used video teaching programme for data collection regarding demographic variables and pre-test. As part of my intervention video teaching programme on knowledge regarding hazards of open defecation people.
The collected data were analyzed by descriptive statistics method (frequency, percentage, and standard deviation) and inferential statistics method ("t"-test). Effectiveness of Video teaching programme on hazards of open defecation in terms of Knowledge. Regarding Knowledge the pre-test mean is 4.4667 and the post-test mean 8.3667, the mean difference is 3.90 and the Standard deviation pre-test 2.11906 and post-test 1.52900, obtained "t" value is 26.37*** with a degree of freedom 59 (p=3.4632) highly significant at 0.001 level.

Keywords: evaluate**,** effectiveness, video teaching program, knowledge, open defecation, hazards, slum people

Introduction

Open defecation (OD), which is the act of relieving oneself in the open or inappropriately disposing of excreta, is a public health concern. Over one billion people engage in the practice worldwide, contributing to many problems, including water contamination and the spread of diseases leading to, among other things, childhood malnutrition. Furthermore, 2.5 billion individuals do not use improved sanitation facilities, which "ensure the hygienic separation of human excreta from human contact" and prevent contamination of the local environment. Poor sanitation and hygiene have been linked to specific negative health outcomes, including diarrheal disease. Although preventable and treatable, diarrheal disease remains the second leading cause of death in children under age five worldwide, resulting in approximately 750,000 deaths annually. Furthermore, observational data has shown an association between childhood diarrhoea and height; interventions that encourage faecal containment are associated with reductions in diarrheal disease and enteric parasite infections. Given the scale and scope of these adverse effects, the UN included sanitation as one of its Millennium Development Goals [1].

Elimination of waste is one of the basic needs of human beings. The term ''Defecation'' is defined as a bowel movement in which feces are evacuated through the rectum and anus. Open defecation is passage of stool in an open environment. It is commonly practiced custom in slum areas where sanitation facilities are ignored.

Human Excreta in open environment causes health hazards like Hookworm infestation, Diarrhea, Cholera, Dysentery and other health problems [2].

Need for the study

''The day every one of us gets a toilet to use, I shall know that our country has reached the pinnacle of progress''
'Jawaharlal Nehru'

WHO and UNICEF report released in May in 2012India accounts for about 60 percent of the world's residents without toilets, according to The country's 50 percent open defecation rate compares with 23 percent in Pakistan, 3 percent in Bangladesh and 1 percent in China, the report said Indian statistics shows that in slum areas where more than half of Mumbai lives an average 81 people share a single toilet. Even the lowest average is still 58 according to local municipal authority figures. The United Nation estimates2009that 55% of Indians still defecates outside, more than 60 years after the scrupulously clean independence leader Mahatma Gandhi first talked of the responsible disposal of human waste. Jack Sim takes a very keen interest in such matters as the founder and president of the world toilet organization (WTO) he has made it his mission to improve sanitation across the globe [3].

India has "a lot of work to do" to improve sanitation, not just because of its impact on health and the spread of disease such as Diarrhea, which UNICEF says kills 1000 Indian children aged under five every day. It also tarnishes the image of a country that likes to portray itself as an emerging

world economic super power, The Singapore businessman said on a visit to Mumbai, where he was promoting world toilet day on November 19 [4].

In march 2009 Mumbai's municipal authorities said there were 77,526 toilets in slum areas and 64157 more were needed work is in progression only 6050. Poor sanitation and the illnesses it cause cost the Indian economy Rs 12 billion a year, according to the health ministry [5].

The study conducted by John L Brushto assess deaths due to typhoid disease in India in a single month, i.e. September 2011reveals that the mortality rate due to typhoid fever is 89/month in India [6].

The first national campaign to target sanitation – the Central Rural Sanitation Program (CRSP) – was launched in 1986, "primarily with the objective of improving the quality of life of the rural people and also to provide privacy and dignity to women. "An additional goal was to provide 25% of the rural population with improved sanitation facilities by the end of the decade. The effort was mostly supply-driven, with a focus on latrine construction. As a result, latrines were built despite low demand and they went largely unused. In 1999, the central government restructured and rebranded CRSP as the Total Sanitation Campaign (TSC). Learning from the disappointing results of CRSP, TSC intended to place greater emphasis on changing behavior and generating demand for toilets. With the aim to make India open defecation-free (ODF) by 2017, the campaign dispersed information, education, and communication (IEC) materials about the negative health consequences of OD. However, while TSC called for greater investment in behavior change, actual implementation was limited. In addition to the information-based behavior change efforts, TSC also offered financial incentives. Households below the poverty line (BPL) received subsidies for toilet construction in the amount of 3,200 rupees if the household contributed 300 rupees. To foster competition among communities and reward achievement, a monetary prize for further sanitation activities – called the Normal Gram Puraskar was given to villages declared ODF. While over 2,000 communities were declared ODF under the NGP, the program was phased out due to the difficulty of verifying ODF status. Despite programmatic changes, TSC also proved ineffectual. Though census data indicates a modest increase in latrine coverage, from 22% in 2001 to 31% in 2011, latrine usage stubbornly lagged behind. In 2012, the TSC was replaced by the Normal Bharat Abhiyan (NBA) with the new goal of providing access to improved sanitation facilities for all rural households by 2022 and enabling all villages to reach ODF status. Under this scheme, Village Water and Sanitation Committees were formed with the task of managing the sanitation program at the local level, and to promote transparency, community participation, inclusion, and ownership.

Under this scheme, toilet construction subsidies increased to 5,500 rupees per household if the household contributed 900 rupees. Additionally, for the first-time households above the poverty line (APL) were eligible for subsidies [7].

The NBA campaign was short-lived, as new Prime Minister Narendra Modi replaced it in October 2014 with the Swachh Bharat Abhiyan (SBA) or "Clean India Mission." Prime Minister Modi updated the goal, calling for an ODF India by 2019. SBA spans a range of actors and government levels and is comprised of two sub-missions geared towards rural (SBA Gramin or SBAG) and urban (SBAU) efforts. In general, the structural guidelines are best understood as a gradual aggregating of implementation plans from each unit of government in the Indian state, with national level plans meant to supplement state plans; the latter includes specific annual activities and a communications and monitoring strategy. Various frontline actors are to carry out sanitation activities, including social health activists (ASHAs), Anganwadi workers, self-help groups, civil society organizations, and a limited number of Swachhata Doots (Swachh Bharat Abhiyan workers) hired specifically for that purpose. In sum, the government expects to spend $22 billion on the initiative,24 with additional spending by NGOs and the World Bank. For comparison, the government allocated approximately $8.3 billion (approximately $41.5 billion if constant over five years) for the entire elementary education program in the 2014-2015 budget [8].

Technological design is essential to addressing the environmental and health challenges in sanitation improvement efforts. Safety considerations largely relate to technical options and variations in the substructure component of a latrine. Variations in the design of toilet superstructures are generally related to usage, take-up, and other behavioral variables. Based on updated World Health Organization (WHO) definitions of safe sanitation and past governmental efforts, the Government of India set out latrine guidelines and criteria under the Swachh Bharat Abhiyan [9].

Current government approaches to sanitation also feature improved recognition of the necessity of different toilet technologies and designs for various geographical conditions. Where possible, the Swachh Bharat Abhiyan recommends connection to underground sewage systems. This is mostly prescribed in urban settings. Yet many major Indian metropolises lack functional water infrastructure due to their fragmented development, and their rapid unplanned and unchecked growth, so these guidelines are rarely applicable in practice [10].

The purpose for selecting slum dwellers for the study is to enhance the knowledge of these peoples regarding hazards of open-air defecation. So that this study would benefit for them. Hence the investigator is interested to enhance the existing knowledge hazards of open-air defecation [11].

Further, the investigator has found from studies that hazards of open-air defecation can easily spread in children in slum population because of lack of sanitation facilities [12].

Objectives of the study

1. To assess the existing level of Knowledge of slum people regarding hazards of open defecation.
2. To evaluate the effectiveness of a Video teaching programme on knowledge regarding hazards of open defecation in terms of Knowledge among slum people at Rajkot.
3. To find out the association between post-test level of knowledge regarding hazards of open defecation and their selected demographic variables.

Hypotheses

H1: There will be a significant difference between pretest and posttest levels of Knowledge of slum people regarding hazards of open defecation.

H2: There will be a significant association between posttest knowledge scores and selected demographic variables.

Material and methodology

Research approach

A quantitative research approach will be adopted for this study.

Research Design

The research design for this study was a pre-experimental research design with one group pre and post-test design will be selected to assess the knowledge regarding hazards of open defecation among people in selected slum area at Rajkot.

Setting: Selected slum area of Rajkot

Population

- **Target population:** Target population is determining by the sampling criteria.
  In my study the target population are people living in slum area of Rajkot.

- **Accessible population:** Accessible population describe the portion of target population to which the research has reasonable access. In my study accessible population are people living in slum area near Ghanteshwar and Madhapar village Rajkot.

Sample: sample size are 60 people living in slum area.

Sampling technique

The researcher adopted convenient sampling technique issued.

- Inadequate knowledge:< 1.7%

Data analysis and interpretation: the collected data was analyzed using both descriptive and inferential statistics.

Result: Major findings

The major findings of the study include

Findings related to a demographic characteristic of subjects

- Majority of 28 (46.7%) respondents were between the age group of 31-40 years.
- Majority of 32 (53.3%) were males.
- Majority of 45 (75%) respondents were unmarried.
- Majority of 44 (73.3%) were from Joint families.
- Majority of 42 (70%) were uneducated.
- Majority of 29 (48.3%) were daily wage workers.
- Majority of 32 (53.3%) were under IV class socioeconomic status.

Conclusion

The main conclusion from this present study is that respondents living in a slum area of Rajkot had inadequate knowledge in pre-test and after planned teaching programme majority of them gained adequate knowledge. Health teaching would prove to be an effective educational method that changes Knowledge of people and improves healthy behaviors among them.

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