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# DESCRIPTIVE STUDY TO ASSESS THE KNOWLEDGE REGARDING PREVENTION OF RESPIRATORY TRACT INFECTIONS AMONG MOTHERS OF UNDER 5 CHILDREN IN SELECTED HOSPITAL OF SRINAGAR KASHMIR.

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**Abstract**

The aim of this study was to assess knowledge regarding prevention of respiratory tract infections among mothers of under 5 children in selected hospital Kashmir. Globally the incidence of acute respiratory tract infections among under-five children is high especially in developing countries. However, the data on ARI is difficult to estimate because they are typically treated in outpatient settings Therefore; the incidence of ARTIs in real-world setting remains largely unexplored. The other systems of children under 5 years of age are in developing stage, so due to weak immune system repeated attacks of infections like diarrhea, gastroenteritis, febrile convulsions and recurrent ARIs occurs usually. Among all of these infections, respiratory tract infections are the most common cause of illness and death in children under 5 years of age. Respiratory infection means an infection of any part of the respiratory tract which includes nasal cavity, pharynx, larynx, trachea, bronchi, lungs etc. Children under 5 years of age will develop three to eight attacks of respiratory illnesses in a year. The prevalence may even be higher in children who attend day care or are exposed to smoking. Most cases are mild, but about one-third of all hospitalized children are due to respiratory problems, including asthma and pneumonia. Therefore, On the basis of evidences a descriptive research design and sixty subjects were selected for this study. Self- Structured interview schedule was used and analyzed by descriptive and inferential statistics using chi-square and t-test. The findings revealed that pre-test mean score was 23.55 SD 6.74 at $p \leq 0.05$. Significant association of pretest knowledge score was found with Monthly family income, Mothers Education, Residence, and Mothers occupation at ($p \leq 0.05$) While as no association was found between Age, Number of under 5 children and Type of family at ($p \geq 0.05$). Hence the investigator partially accepted the Research hypothesis and partially rejected the Null hypothesis.

**Key Words: -** Assess, Knowledge, Respiratory Tract Infection, Children under 5 years and Mothers.

## 1. INTRODUCTION

The common cold is the most frequent infectious disease in children occurs with average two to four infections in adults and six to eight in under five children's per year. Collectively colds, influenza, and other infections with similar symptoms are included in the diagnosis of influenza-like illness. They may also be termed upper respiratory tract infections in which Influenza involves the lungs while the common cold does not.[1]

Infections of the respiratory tract are the most common ailment in children. Every year acute respiratory tract infections are responsible for an estimated 4.1 million deaths worldwide. It is estimated that Bangladesh, India, Indonesia, and Nepal together account for 40% of the global ARI mortality. About 90% of the ARI are due to pneumonia. On an average, children below 5 years of age suffer about 5 episodes of ARI which are responsible for about 30% to 50% of visits to health facilities and for about 20-40% of admissions to hospitals. In India, in the states and districts with high infant and child mortality rates, ARI is one of the major causes of death. Hospital records from states with high infant mortality rates show that up to 13% of inpatient deaths in paediatric wards are due to ARI.[2]

The acute respiratory tract infection ranks second in the mortality rate of children 1-4 years of age group. The respiratory tract infections are described according to the anatomic area of involvement. The upper respiratory tract infections are common cold, Pharyngitis, Tonsillitis and lower respiratory tract infections include bronchitis, pneumonia.[3]

Some viral and bacterial diseases also cause upper respiratory tract infections in toddler. Measles is a highly infectious disease of children caused by specific viruses called mixo-viruses. It is endemic and virtually in all part of the world. It tends to occur in epidemics when the proportion of susceptible children reaches about 40%. Measles killed between 7-8 million children in a year. Diphtheria and whooping cough are the other diseases which causes upper respiratory tract infections in children. The reported cases of diphtheria in Thailand were 31 cases and Laos was 300 cases in the age between 1-3 years. At the same time whooping cough also causes mortality among young children, in 2002 it killed around 2.95 lakh persons. [4]

The common cold leads to approximately 75 to 100 million physician visits annually. An estimated 22 to 189 million school days are missed annually due to a cold, which affects working parents with approximately 126 million workdays staying home to care for their children. Add this to the approximately 150 million workdays missed by employees suffering from a cold, which accounts for approximately 40% of time lost from work in the U.S., and you can see why the "common" cold is referred to as the most "common" human disease. Common colds are not a trivial health problem, as these statistics indicate, and that can be attributed to the fact that there simply is no cure for the common cold and the fact that it is highly contagious. However, the symptoms can be treated, and compounding pharmacists can work with the patient and the physician in this endeavor.[5]

The corzya (common cold) or acute naso-pharyngitis is the most common respiratory infection in infants and children .In addition to the nasopharynx, the accessory paranasal sinuses and middle ear are generally involved. The common cold (viral upper respiratory tract infection (VURTI), acute viral rhino-Pharyngitis, acute coryza, or cold) is a contagious, viral infectious disease of the upper respiratory system, caused primarily by rhinoviruses(30-50%) and corona viruses (10-15%).[7] As the common cold mainly affects the upper respiratory tract, i.e. nose, throat and the wind piped and symptoms are similar. A cold often starts with a "tickle" in the throat, a runny or stuffy nose and sneezing. Children with cold may also have a sore throat, cough, headache, mild fever, fatigue, muscle aches, and loss of appetite. Cold usually takes seven to 14 days in recovery. In case of an added infection by the bacteria or complications like sinusitis, ear infection, laryngitis or bronchitis occur, the illness will be prolonged.[6]

According to WHO estimate respiratory infections caused about 987,000 deaths,out of that 20,000 were due to acute upper respiratory tract infection. The burden of the disease in terms of disability adjusted life year (DALYs) lost was 25.5 million of these 2.74 lakh due to acute respiratory tract infection. [7]

In India some bacterial and viral diseases also causes the upper respiratory tract infections. Measles causes morbidity and mortality in children. Diphtheria and whooping cough also causes child mortality and morbidity. Incidents of the diphtheria in the country were about 12952 whereas the cases of whooping cough were 26.7 thousands.[4]

A study was conducted to determine epidemiological characteristics that are occurrence of Respiratory Syncytial Virus (RSV) infection in Croatian children with acute respiratory tract infection. The Croatian national institute of public health tested nasopharyngeal secretion obtained from 1232 patients most of whom were hospitalized for acute respiratory tract infection. Most often the virus demonstrated was respiratory syncytial virus (RSV) 48%, other respiratory viruses were shown considerably less common (5.1%). The incidence of respiratory syncytial virus is more common among toddler.[8]

A report by Director General of Health Services, Government of India, indicated that ARI contributes towards about one-third to one-fourth of all under five deaths in India and it stands at 52nd rank in the global scenario of under-five morality in the world.[14] It is sad to learn that in our global community, almost 10.5 million children die every year i.e., 30,000 children die a day, 21 children die in a minute every day before reaching their fifth birthday due to various infections. Ninety percent of these under five children have died due to ARI.[9]

Bijapur BS (2009) conducted a descriptive study in Dharwad on the effectiveness of planned teaching programme on prevention of pneumonia among mothers of children having acute respiratory infection. One group pre-test post-test

design was adopted to conduct the study and sample taken were 60 mothers of under-five children. Structured questionnaire was used in this study. The pre-test scores shows that 14 mothers had (23.33%) inadequate level of knowledge and 46 mothers had (76.67%) moderate level of knowledge and the post-test scores after the planned teaching programme shows that 59 mothers had (98.33%) adequate knowledge and only 1.67% with moderate level of knowledge. This shows that there is significant difference in the pre-test and post-test level of knowledge and it is significant at $p<0.001$. This study concludes that planned teaching programme is effective in enhancing knowledge of mothers regarding pneumonia and this study conclude that it is the responsibility of health workers to organize such educational programmes in community.[10]

Sherene G.Edwin, (2007) Children are tomorrow's adults. This 21st century belongs to them and to their children and grand-children. They and their descendants are deserved to enjoy all the health facilities. Moving along with the acute respiratory infection control programme since 1978 the health professional's efforts should be directed towards charting a better healthier future for humanity, a future in which millions of children no longer face death in infancy and childhood. To make such a change present day our challenge to gain a better understanding that makes a difference in the prevalence of these problems affecting health of the children. Family members especially the mothers have an important role in preventive aspects and through that health promotion in their children.[11]

Pai Mamatha Shivanada (2014) conducted a descriptive study to assess the incidence of acute respiratory tract infection (ARI) among infants in selected area of Udpai district. 110 mothers and infants above three months were selected for study. Structured interview schedule was used for data collection. Majority of children that is 60.9% had ARI 4 to 6 times in past three months. During one-month observation, maximum number of children (48.6%) had at least suffered from ARI once. Chi square values computed between occurrence of ARI and selected variables revealed significant association between occurrences of ARI and physical health of the infant and environment pollution. The results of the study revealed that majority of children suffered 4-6 times with respiratory tract infection in three months of study period.[12]

MitraNilanjan Kumar (2011) conducted a longitudinal study on ARI in rural areas of Durgarampur Singur Hooghly among under five children . This longitudinal study was formulated with the objective to determine the ARI morbidity among the rural under five and to study some of the epidemiological factors responsible for such morbidity. All 63 children less than 5 years of age (population 548) in Singur block of district Hooghly were included in the study. Children were followed up with periodic home visits at two weeks interval for 6 months. Frequency of ARI episodes was studied and association variables was analyzed. Overall incidence density rate of ARI episodes was 19.57 / 100 children per month at risk. Incidence was highest in infants 23.9/100 children per month. Risk ratio analysis showed that low socio-economic class, low birth weight, under nutrition, inadequate immunization, children not exclusively breastfed and indoor smoke pollution were significantly associated with increasing number of ARI episodes. The study strongly point towards the importance of basic health promotional measures like proper infant feeding practices, proper nutrition of the child, and improved general conditions of living in prevention and control of ARI.[13]

Rochat MK (2010) conducted a cohort study on weather rhinitis is a predictor for childhood school asthma in Germany. The Study included 1314 healthy children. They were followed from birth to the age of 5 years .Data was collected from mothers using regular questionnaires and interviews. Specific IgE levels were measured at yearly intervals. Airway hyper responsiveness was assessed at 7 years.Allergic rhinitis until the age of 5 years was found to be a predictor for developing wheezing between the ages of 5 and13 years. In this age group of children, 41.5% of all new cases of wheezing occurred among children with preceding allergic rhinitis.The first manifestation of allergic rhinitis occurs in preschool children in whom it is a predictor for Subsequent wheezing onset. Pre-school children with rhinitis might be thus benefited from early assessment of allergy sensitization to identify the children at high risk of wheezing.[14]

Pappas DE (2008) conducted a descriptive study about symptom profile of common colds in school-aged children. 81 subjects were taken under study, Signs and symptoms of a common cold reported in young children are those perceived by caretakers. Objective signs include cough, fever, and sneezing. Subjective symptoms include nasal congestion, fever, headache, and sore throat. Pre-printed diary sheets listing common signs and symptoms, were kept for School-aged children for 10 days after onset of a cold. Nasopharyngeal aspirates were analyzed for respiratory viruses and potential bacterial pathogens. Result out of 81 study subjects; most common signs were cough and sneezing and most common symptoms were nasal congestion and runny nose. Other symptoms, including fever and headache, were reported in 15% of children at onset. The majority of children (73%) continued to be symptomatic for 10 days after onset. Rhinovirus was detected in 46%.[15]

DCP.SK (2008) conducted a correlational study in West Tripura district, to determine the incidence, causes, risk factors, morbidity and mortality associated with acute respiratory infections (ARI) and impact of simple case management in children under 5 years of age. The annual attack rate (episode) per child was more in urban area than in rural area. Monthly incidence of ARI was 23% in urban area, 17.65% in rural area. The overall incidence of ARI was 20%. The incidence of pneumonia was 16 per 1000 children in urban area and 5 per 1000 in rural area. The incidence of pneumonia was found to be the highest in infants group; 3% of ARI cases in rural area and 7% in urban area developed pneumonia. Malnourishment in urban area was 54% and in rural area 65%. Malnourished children have higher likelihood for developing respiratory infection. The relative risk (RR) of developing pneumonia was 2.3 in malnourished children.

Most children (59%) had been immunized with measles and diphtheria, pertussis and tetanus (DPT) vaccine earlier. The immunization had a protective role in pneumonia. Air pollution of the urban area had stronger relation for bronchial asthma than pneumonia. Breastfeeding had protective role in pneumonia.[16]

Verema I.C. (2006) conducted a descriptive study to assess the knowledge on causes of acute respiratory infection in children from 1 month to 15 years of age . The overall detection rate was 57.9%. The mostly frequently detected organisms were Para influenza 12.6%,, adenovirus 11.2% influenza 7.3%, ,respiratory syndrome 6%, ,M. Pneumonia 5.4%, C.trachoma 3.5% and mixed infections 9.2% .Pneumonia was associated most frequently with adenovirus and mixed infection, wheezing bronchitis with adenovirus respiratory syndrome viruses and M.Pneumonia bronchitis with Para influenza and adenovirus.[17]

M.M Katherine Hutchinson (2006) conducted a descriptive study to provide an overview of the incidence of upper respiratory tract infection out brakes in toddler day care centers among toddlers. Results of the study concluded with a review of infection control measures, research findings on the effectiveness of certain practices and suggested for the implementation of effective infection control measures.[18]

Anita P, Rama C, Lata K, Kabra1 SK (2005) conducted a study on incidence of acute respiratory tract infections (ARI) and acute lower respiratory infections (ALRI) in children less than 5 years old in urban slum communities in Manila. The peak age-specific incidence occurred in those children 6-23 months old for ARI and 6-11 months old for ALRI. Age less than 2 years, malnutrition, household overcrowding, and parental smoking were associated with a statistically significant increase in ARI morbidity. The crude mortality rate was 14.3 per 1,000 children 0-4 years old, with a corresponding ARI-specific mortality rate of 8.9 per 1,000. The prevalence of viral infection was 32.8 and bacteremic ALRI was 6.7 per 1,000 children with moderate ALRI. Respiratory syncytial virus was the predominant viral pathogen, while Streptococcus Pneumoniae, Haemophilus Influenzae, and Staphylococcus Aureus were the most frequently isolated bacterial pathogens. Transmission of respiratory pathogens in urban slum communities, facilitated by inadequate housing, inaccessible health services, and prevalent malnutrition, will continue unless meaningful socioeconomic improvement is realized.[19]

Celia. M. Alpuche (2005) conducted a descriptive study on incidence of common cold among toddlers in urban area. The results of the study revealed that unlike bacteria, virus is the organism that is small and incorporates itself into the body's cell. On average toddler get 8 to 10 viral infection per year.[20]

M.F.E.I Syed (2004) conducted a study to determine epidemiological characteristics on occurrence of respiratory syncytial virus(RSV) infection among Croatian children with acute upper respiratory tract infection. Most often virus demonstrated was RSV(43.8%)and other respiratory virus (5.1%) The finding of the study revealed that respiratory syncytial virus is the common cause of upper respiratory tract infection in Croatian young children. Its annual outbreak occurring in winter season.[21]

Kumar M, Biswal N, Bhubaneswar V, Srinivasan S(2009) conducted a study to identify the causes and contributing factors of persistent bronco pneumonia in under five children comprising of 41 cases. Out of 41 cases, 8 had pulmonary tuberculosis and 12 had Gram negative bacterial infections, 12 had aspiration due to gastroesophageal reflux disease or oil instillation, 3 had immunodeficiency due to HIV infection, 2 had congenital lung malformation, 2 had cardiac disorders and one had foreign body aspiration as causes of persistent bronchopneumonia. The most common underlying cause of persistent pneumonia were persistent infection followed by aspiration and acquired immune deficiencies.[22]

## 2. OBJECTIVES OF THE STUDY

1. To assess the knowledge regarding prevention of respiratory tract infections among mothers of under 5 children in selected hospital of Srinagar Kashmir.
2. To find the association between knowledge regarding prevention of respiratory tract infections among mothers of under 5 children in selected hospital of Kashmir with their demographic variables i.e., Age, Education, Occupation, Family income, Type of family ,Number of under 5 children & Residence .

## 3. MATERIALS AND METHODS

A descriptive research design was conducted to assess the knowledge regarding prevention of respiratory tract infections among mothers of under 5 children in selected hospital of Srinagar Kashmir. Sixty subjects were selected by Purposive sampling technique. The tool consisted of demographic variables and self-structured questionnaire. Prior to data collection informed consent was obtained from the participants. The data was collected for analysis by using descriptive and inferential statistics.

## 4. RESULTS

**Table no. 1: frequency and percentage distribution of study subjects according to their age.**

**n=60**

| Age in years | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| 15-30 | 34 | 56.66 |
| 31-45 | 26 | 43.33 |
| Above 45 | 0 | 0 |

The data presented in table 1 revealed that out of 60 study subjects, majority 34 (56.66%) were in the age group of 21-30 years, 26(43.33%) were in the age group of 31-40 years, none of the subjects were in the age group of between 0-20 years and above 40 years.

**Table no. 2: Frequency and percentage distribution of study subjects according to their education.**

**n=60**

| Mothers Education | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| Illiterate | 7 | 11.7 |
| Middle Pass | 6 | 10 |
| Secondary | 16 | 26.7 |
| Higher Secondary | 14 | 23.3 |
| Graduate | 13 | 21.7 |
| P.G and above | 4 | 6.7 |

The data presented in table 2 revealed that of the 60 study subjects 7 (11.7%) of the subjects were illiterate, 6 (10%) were middle pass, 16(26.7 %) were educated up to secondary level, 14 (23.3%) were educated up to higher secondary level, 13 (21.7%) were graduates and 4(6.7%) were post graduates and above.

**Table no. 3: Frequency and percentage distribution of study subjects according to their number of under five children in years.** **n=60**

| No. of under five children in years | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| 1 | 29 | 48.3 |
| **2** | 31 | 51.7 |
| 3 | 0 | 0 |
| 4 and more | 0 | 0 |

The data presented in table 3 revealed that out of 60 study subjects 29(48.3%) had children under one year of age, 31(51.7%) had children under two years of age and none of the subjects had more than two years of age.

**Table no. 4: Frequency and percentage distribution of study subjects according to their Residence.**

**n=60**

| Residence | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| Urban | 19 | 31.7 |
| Rural | 41 | 68.3 |

The data presented in table 4 revealed that out of 60 study subjects, 19 (31.7%) of subjects were from urban area, and 41(68.3%) were from rural area.

**Table no. 5: Frequency and percentage distribution of study subjects according to their Type of family. n=60**

| Type of family | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| Nuclear | 25 | 41.7 |
| Joint | 35 | 58.3 |
| Extended | 0 | 0 |

The data presented in table 5 revealed that out of 60 subjects 25 (41.7%) of the subjects belongs to nuclear family and 35 (58.3%) belongs to joint family and none belongs to extended family

**Table no. 6: Frequency and percentage distribution of study subjects according to their Monthly family income. n=60**

| Monthly family income | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| < 15,000 | 11 | 18.3 |
| 15000-30000 | 30 | 50.0 |
| > 300000 | 19 | 31.7 |

The data presented in table 4 revealed that out of 60 study subjects, 11 (18.3%) of the subjects had < 15,000 family income/ month, 30(50.00%) had between 15,000 to 30,000 family income/ month and 19 (31.7%) had > 30,000family income/ month respectively.

**Table no. 7: Frequency and percentage distribution of study subjects according to their Mothers Occupation. n=60**

| Mothers Occupation | Study Subjects | |
|---|---|---|
| | Frequency | Percentage |
| House wife | 42 | 70.0 |
| Government employee | 16 | 26.7 |
| Private employee | 2 | 3.3 |

The data present in table 4 revealed that out of 60 study subjects 42(70.0%) were house wives, 16(26.75%) were government employees and 2(3.3%) were private employees.

**Table No. 8: Mean, Median, S.D, Range of pretest knowledge score of subjects regarding prevention of Respiratory Tract Infections.**

| Level of Knowledge | Mean | Median | S.D. | Range | Minimum | Maximum |
|---|---|---|---|---|---|---|
| Pre-test score | 23.55 | 22.50 | 6.746 | 29 | 12 | 41 |

The data presented in table 5 revealed that mean pre-test score 23.55, median 22.5, standard deviation 6.74 & range 29 at $p \leq 0.05$ were found in the pretest.

**Table no. 9: Association Between Pre–Test Knowledge Scores Of Study Subjects With Selected Demographic Variables.**

n=60

| Variables | Category | Frequency | Pretest Knowledge | | | df | Chi Sq. Test $\chi^2$ | P Value | Remark |
|---|---|---|---|---|---|---|---|---|---|
| | | | Inadequate | Moderate | Adequate | | | | |
| Age | 21-25 | 4 | 1 | 3 | 0 | 6 | 10.368 | 0.110 | Not Significant |
| | 26-30 | 30 | 23 | 5 | 2 | | | | |
| | 31-35 | 22 | 15 | 4 | 3 | | | | |
| | 36-40 | 4 | 4 | 0 | 0 | | | | |
| Mothers Education | Illiterate | 7 | 7 | 0 | 0 | 10 | 93.235 | 0.000 | Significant |
| | Middle Pass | 6 | 6 | 0 | 0 | | | | |
| | Secondary | 16 | 16 | 0 | 0 | | | | |
| | Higher Secondary | 14 | 13 | 1 | 0 | | | | |
| | Graduate | 13 | 1 | 11 | 1 | | | | |
| | P.G and above | 4 | 0 | 0 | 4 | | | | |
| No. of under five children | 1 | 29 | 19 | 6 | 4 | 2 | 2.317 | 0.314 | Not Significant |
| | 2 | 31 | 24 | 6 | 1 | | | | |
| | 15000-30000 | 30 | 24 | 5 | 1 | | | | |
| | > 300000 | 19 | 9 | 6 | 4 | | | | |
| | Joint | 35 | 24 | 8 | 3 | | | | |
| Residence | Urban | 19 | 9 | 6 | 4 | 2 | 9.552 | 0.008 | Significant |
| | Rural | 41 | 34 | 6 | 1 | | | | |
| | Government employee | 16 | 9 | 4 | 3 | | | | |
| | Private employee | 2 | 0 | 1 | 1 | | | | |
| Monthly family income | < 15,000 | 11 | 10 | 1 | 0 | 4 | 10.024 | 0.040 | Significant |
| | 15000-30000 | 30 | 24 | 5 | 1 | | | | |
| | > 300000 | 19 | 9 | 6 | 4 | | | | |
| Type of family | Nuclear | 25 | 19 | 4 | 2 | 2 | 0.461 | 0.794 | Not Significant |
| | Joint | 35 | 24 | 8 | 3 | | | | |
| Mothers Occupation | House wife | 42 | 34 | 7 | 1 | 4 | 11.838 | 0.019 | Significant |
| | Government employee | 16 | 9 | 4 | 3 | | | | |
| | Private employee | 2 | 0 | 1 | 1 | | | | |

The data presented in Table 9 revealed that significant association was found between Monthly family income, Mothers Education, Residence, and Mothers occupation of study subjects with their pre-test knowledge scores; While as no association was found between Age, Number of under 5 children and Type of family of study subjects with their pre-test knowledge scores ($p \geq 0.05$). Hence the investigator partially accepted the Research hypothesis ( $H_2$: There is significant association between pre-test knowledge scores of mothers with selected demographic variables) and partially rejected the Null hypothesis ($H_0$ : There is no significant association between pre -test knowledge scores of subjects with their selected demographic variables) .

## 5. DISCUSSION

The major findings of the study were compared with the similar studies conducted by other researchers. The findings of the study were discussed as per the objectives and hypotheses. The findings of the study showed that in pre-test out of 60 study subjects majority of study subjects 43( 71.7%) had inadequate, 12(20.0%) had moderate & 5(8.3%) had adequate knowledge regarding management of respiratory tract infections.

The findings of the study are supported by the descriptive study conducted by Mamata Jena (2014)[23] to assess the effectiveness of information booklet on knowledge & practice about prevention of pneumonia among mothers of under five children admitted to pediatric ward of M.K.C.G M.C.H, Berhampur, Odisha. The findings revealed that 68% of mothers had inadequate knowledge 20% of mothers had moderate knowledge ,and 12% of mothers had adequate knowledge regarding prevention of pneumonia in children with mean knowledge score of 11.54.

These findings of the study are supported by the descriptive study conducted by Asha D etal (2013)[24] to assess the effectiveness of structured teaching programme on knowledge regarding prevention and management of respiratory tract infection among mothers of under 5 children in selected community areas of Mangalore.The findings of the study revealed that 74% of mothers had inadequate knowledge 18% of mothers had moderate knowledge ,and 8% of mothers had adequate knowledge regarding management and prevention of respiratory tract Infection in children with mean knowledge scores 14.12 and mean percentage 47.06%.

The present results are supported by the findings of a quasi-experimental study conducted by Sachin Mali Sinhgad (2012)[25] to assess effectiveness of structured teaching programme on knowledge of domiciliary management and prevention of upper respiratory tract infections among mothers of under five children in selected urban slums of Bangalore .The sample consisted of 60 mothers, experimental Group- 30 and Control Group -30. Purposive sampling technique was adapted to select subjects. Results of the study showed that among 30 mothers in experimental group 17 % have adequate knowledge, 50% have moderate knowledge and 33% have inadequate knowledge regarding management and prevention of upper respiratory tract infections.

The association of demographic variables with pre-test knowledge scores by using Chi –square test revealed that there was statistically significant association between pre-test knowledge score with selected demographic variable as Mothers Education, family income, Residence and mothers occupation at $p \leq 0.05$ level while as no significant association was found with Age , type of family and Number of under 5 children.

The present results were similarly found in a descriptive study conducted by Siswanto E, bhuiyan S.U, Chompikul J. ( 2006 )[26] to assess Knowledge and Perception of Pneumonai Disease among Mothers of Children under Five Years attending Nakhon Pathom General Hospital, Thailand where there is statistically significant association between pre test knowledge score with selected demographic variable as Monthly family income, Mothers Education, Residence and Mothers Occupation evidenced that there was statistically association at $p \leq 0.05$ level. No significant association was found with age and type of family[18].

Similar results were found in a descriptive study conducted by Thamer.K.Yousif .BAN A. Khaleq (2005)[27] to assess the Epidemiology of acute respiratory tract infections in children under five years attending Tikrit General Teaching Hospital where there is statistically significant association between pre test knowledge score with selected demographic variable as Monthly family income, Mothers Education, evidenced that there was statistically association at $p \leq 0.05$ level. No significant association was found with Age and Type of family and residence.

## 6. CONCLUSION:

This study was conducted with the objective to assess the knowledge regarding prevention of respiratory tract infections among mothers of under 5 children in selected hospital Srinagar Kashmir. The findings concluded that majority of the study subjects were not having good knowledge. The findings also revealed that there was significant association between pretest knowledge score with these demographic variables(mothers education, family income, residence and mothers occupation while as no association was found between pre-test knowledge score with these demographic variables ( age, type of family and number of under 5 children in years). So it indicates that there is need to enhance the knowledge among mothers of under of 5 children regarding prevention of respiratory tract infections.

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## 8. CONFLICT OF INTEREST AND FUNDING

As such there was a bit conflict and compromise between the mothers and investigator because the mothers were not ready to cooperate while doing pre-assessment on knowledge regarding prevention of acute respiratory tract infections. Moreover, the investigator first motivated the mothers regarding the benefits of this study. In addition of this, the fact is that mothers remain very busy in their house holding activities and are getting very less time to achieve such type of opportunities during their life. The investigator also felt that there should be planned teaching programmes, awareness programmes, demonstrations in order to enhance the level of knowledge for mothers of under 5 children. The investigator also done this work very ethically without getting any fund or any support from any organization.

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