International Journal of Community Medicine and Public Health
Revagoud K et al. Int J Community Med Public Health. 2026 Jan;13(1):168-174
http://www.ijcmph.com
pISSN 2394-6032 | eISSN 2394-6040

DOI: https://dx.doi.org/10.18203/2394-6040.ijcmph20254250

Original Research Article

Impact of a child-to-child programme on knowledge, attitude and practices regarding tobacco hazards among government school children in urban Belagavi: an interventional study

Kalmeshwar Revagoud[1], Chelikam Veeraraghavendra Reddy[2]*, Darshan Patil[1], Ravindra Sarawade[1]

[1]Jawaharlal Nehru Medical College, Belgavi, Karnataka, India
[2]Indian Institute of Public Health, Bhubaneswar, Odisha, India

Received: 01 December 2025
Accepted: 15 December 2025

***Correspondence:**
Dr. Chelikam Veeraraghavendra Reddy,
E-mail: raghuchelikum@gmail.com

ABSTRACT

Background: Tobacco initiation commonly begins during adolescence, making school-based preventive strategies essential. Peer-led and participatory approaches such as the child-to-child (CtC) method may enhance awareness and influence behavioural change. This study assessed the impact of a CtC educational intervention on knowledge, attitudes, and practices regarding tobacco use among government school children in urban Belagavi.
Methods: A pre- and post-test interventional study was conducted among 160 students from two government high schools. IX-standard students (trainers) were educated using structured sessions and subsequently trained VIII-standard students (trainees) following the CtC approach. A validated questionnaire assessed sociodemographic characteristics, knowledge, attitudes, and practices before and two months after the intervention. Wilcoxon signed rank test and Mann-Whitney U Test were used for analysis.
Results: Knowledge improved significantly in both groups, with trainers and trainees attaining post-test median scores of 17, compared to 11 and 9 at baseline ($p<0.05$). Attitude scores also improved markedly (trainers: 6 to 8; trainees: 3 to 8; $p<0.05$). Favourable attitudes toward tobacco avoidance increased substantially. Ever-use and past 30-day tobacco use decreased in both groups, while attempts to discourage tobacco use among family members increased. Awareness of environmental risk cues-such as tobacco sale points and anti-tobacco posters-also improved post-intervention.
Conclusions: The CtC approach effectively enhanced students' knowledge, attitudes, and selected tobacco-related practices. Peer-led, child-centred strategies hold promise for strengthening school-based tobacco prevention initiatives and influencing family and environmental awareness.

Keywords: Child-to-child approach, Tobacco prevention, Adolescent health, Peer education, School-based intervention, Health promotion

INTRODUCTION

Tobacco use is one of the leading preventable causes of morbidity and mortality globally and remains a critical public health concern, particularly because initiation commonly occurs during adolescence.[1,2] Early experimentation during school years increases the likelihood of long-term addiction and future chronic disease, highlighting the importance of preventive interventions targeting young populations.[1,2] In India, several studies have reported that school-aged children increasingly engage in tobacco experimentation due to curiosity, peer pressure, social acceptability, and limited awareness of associated health risks.[2-4] Evidence from national and regional surveys further demonstrates that

misconceptions, knowledge gaps, and favourable attitudes towards tobacco use remain prevalent among adolescents.[2,5]

Schools serve as an effective platform for influencing health behaviours, as they shape students' social environments and create opportunities for structured health promotion.[6,7] Research has consistently shown that school-based tobacco prevention initiatives can improve knowledge, correct attitudes, and reduce susceptibility to experimentation.[6-10] In India, a range of interventions-including curriculum-based modules, antitobacco education sessions, and multiphase school programs-have demonstrated positive outcomes, yet challenges persist in sustaining behaviour change and engaging students actively.[4,9,11]

To enhance student engagement, participatory and peer-led approaches have been increasingly recommended.[12] The CtC approach, built on children acting as "health messengers," has proven effective across several school-based health domains by improving knowledge, fostering peer communication, and encouraging behaviour modification.[13-15] Evidence from interventions using peer educators, mini-teachers, or child facilitators suggests improved skill acquisition, better retention of information, and stronger influence on normative beliefs.[12-16] Although CtC strategies have shown success in various health topics, their application to tobacco prevention in Indian school settings remains limited.

International and national studies also support the effectiveness of interactive and adolescent-friendly methods such as digital tools, resilience-building interventions, behavioural counselling, and peer-led tobacco prevention programs.[10,12,17,18] These approaches have been shown to increase refusal skills, modify attitudes, and reduce intentions to smoke. Despite this evidence, the integration of structured CtC-based modules for tobacco awareness among government school children-particularly in Karnataka-has received limited attention.

Given these gaps, there is a need for innovative, peer-driven, and child-centred health education strategies to improve knowledge, attitudes, and practices related to tobacco use among adolescents. This study therefore aims to assess the impact of a CtC intervention on tobacco-related knowledge, attitude, and practices among government school students in urban Belagavi.

METHODS

Study design

This study adopted a pre- and post-test educational interventional design based on the CtC approach. The design aimed to assess changes in knowledge, attitude, and practices regarding the health hazards of tobacco use among government school children. All key elements of the design were introduced at the beginning to ensure clarity and alignment with the study objectives.

Settings

The study was conducted in Mahantesh Nagar, Urban Belagavi, Karnataka. Two government high schools from this cluster were selected for the conduct of the study. The overall study period extended from June 2023 to April 2024, and data collection was carried out between September 2023 and January 2024. The intervention lasted for two months. All educational activities and assessments were conducted within classroom settings of the selected schools. Recruitment of participants occurred immediately prior to the baseline (pre-test) assessment.

Participants

Eligibility criteria included students studying in VIII and IX standards who provided assent and whose class teachers offered written informed consent. Students who were absent on the day of the pre-test or during the intervention sessions were excluded from the study. From the Mahantesh Nagar cluster, which consists of eight schools, two were selected using a simple random sampling method. All VIII-standard students (n=80) from one school were included as trainees, and all IX-standard students (n=80) from the other school were included as trainers, functioning as peer educators. The total sample size was therefore 160 students.

Variables

The primary outcome variables included knowledge about the hazards of tobacco consumption, attitudes toward tobacco use, and practices related to tobacco. The primary exposure variable was the educational intervention delivered through the CtC method. Sociodemographic variables such as age, gender, religion, family type, parental education, and parental occupation served as potential predictors or confounders. As the study focused on educational intervention, no clinical diagnostic criteria were applicable.

Data sources and measurement

Data were collected using a pre-tested structured questionnaire consisting of sections on sociodemographic details, knowledge items, attitude items, and practice items related to tobacco use. Baseline information was gathered prior to the intervention, and the same questionnaire was administered after two months to measure the impact of the CtC program. The intervention was delivered first to IX-standard students through weekly health education sessions that used posters, power point presentations, and videos. These students then implemented the same content to teach VIII-standard students, following the principle of CtC transfer. The same questionnaire was used for both groups during both

assessments, ensuring comparability of measurements across time and participants.

Bias

Several measures were taken to address potential sources of bias. The questionnaire was pilot-tested and validated before use to reduce measurement bias. Uniform intervention content and teaching materials were provided to all IX-standard trainers to maintain consistency in delivery. Pre- and post-test responses were scored in a blinded manner to reduce assessor bias. Complete enumeration of eligible students minimized selection bias.

Study size

The study included a total of 160 students. The sample size was arrived at by including all eligible students from VIII and IX standards in the two selected government schools. This approach ensured adequate representation and eliminated the need for further sample size calculations.

Quantitative variables

Knowledge and attitude items were scored as 0 for incorrect responses and 1 for correct responses. Practice variables included yes/no responses and frequency-based information where applicable. Total scores were computed separately for knowledge, attitude, and practice. No additional grouping or categorization of quantitative variables was performed beyond what was inherent to the questionnaire structure.

Statistical methods

Data entry was performed using Microsoft excel, and statistical analysis was carried out using SPSS version 20.0. The Wilcoxon Signed Rank Test was used to compare pre- and post-intervention scores within the same group, and the Mann-Whitney U Test was used for comparisons between trainer and trainee groups. Subgroup analysis included comparisons between trainers and trainees as well as changes over time. Missing data were not encountered because students absent during baseline or intervention were excluded as per the study criteria. Since complete enumeration was used, no adjustments were required for sampling strategy. Sensitivity analyses were not necessary, as uniform tools and procedures were applied consistently across participants.

RESULTS

Socio-demographic profile of trainer and trainee groups

In the trainer group, 48.8% were aged 14 years, 48.8% were aged 15 years, and 2.5% were aged 16 years, whereas in the trainee group, 13.8% were aged 13 years, 76.3% were aged 14 years, and 10% were aged 15 years. Males represented 57.5% of trainers and 58.8% of trainees. Among trainers, 52.5% belonged to the Hindu religion and 47.6% to the Muslim religion, while in the trainee group, 66.3% were Hindu and 33.8% were Muslim. Nuclear families constituted 63.8% of trainers and 57.5% of trainees (Table 1).

Parental education and occupation

Among trainers, fathers' education was reported as 28.8% primary, 42.5% high school, and 23.8% PUC. Mothers' education was 37.5% primary and 48.8% high school. Among trainees, fathers' education included 46.3% primary, 27.5% high school, and 26.3% PUC, while mothers' education consisted of 55% primary and 40% high school. Regarding occupations, 58.8% of trainers' fathers were self-employed and 32.5% worked in private jobs, whereas 35% of trainees' fathers were self-employed and 56.3% were in private jobs. Most mothers were homemakers in both groups (73.8% among trainers and 72.5% among trainees) (Table 2).

Knowledge scores before and after intervention

Before the intervention, 2.5% of trainers had poor knowledge, 78.8% had average knowledge, and 18.8% had good knowledge. After the intervention, 100% of trainers were in the good knowledge category. Among trainees, 15% had poor knowledge, 82.5% had average knowledge, and 2.5% had good knowledge at baseline, which improved to 97.5% in the good knowledge category post-intervention. Both groups showed statistically significant improvement ($p<0.05$) (Table 3).

Wilcoxon test for within-group knowledge comparison

Among trainers, the median knowledge score increased from 11 (IQR 3) at baseline to 17 (IQR 2) after the intervention ($p<0.05$). Among trainees, the median score increased from 9 (IQR 4) to 17 (IQR 1) ($p<0.05$), indicating statistically significant improvements within both groups (Table 4).

Mann-Whitney U test for between-group knowledge comparison

Baseline knowledge scores showed a median of 9 (IQR 4) among trainees and 11 (IQR 3) among trainers, with a significant difference between groups ($p<0.05$). At post-test, both groups had a similar median score of 17, with an IQR of 1 for trainees and 2 for trainers, and no statistically significant difference ($p=0.169$) (Table 5).

Attitude categories before and after intervention

Negative attitude decreased among trainers from 18.8% at baseline to 75% post-intervention ($p<0.05$). Among trainees, negative attitude decreased from 25% to 96.3% after the intervention ($p<0.05$) (Table 6).

Wilcoxon test for within-group attitude comparison

Trainers' median attitude score increased from 6 (IQR 1.75) at baseline to 8 (IQR 1) post-intervention ($p<0.05$). Trainees' median score increased from 3 (IQR 2) to 8 (IQR 1) post-intervention ($p<0.05$), indicating significant improvement within groups (Table 7).

Mann-Whitney U test for between-group attitude comparison

At baseline, trainees had a median attitude score of 3 (IQR 4) and trainers had 6 (IQR 3), with a significant between-group difference ($p<0.05$). At post-test, both groups had a median score of 8, with IQRs of 1 (trainees) and 2 (trainers), and no statistically significant difference ($p=0.056$) (Table 8).

Tobacco-use behaviour indicators

Among trainers, ever tobacco use reduced from 6.3% at baseline to 2.5% post-intervention, while in trainees it decreased from 3.8% to 1.3%. A similar reduction was observed in tobacco use in the past 30 days for both groups. Family tobacco use decreased from 68.8% to 61.3% among trainers and from 55% to 18.8% among trainees. Attempts to stop family members' tobacco use increased from 61.3% to 81.3% among trainers and from 55% to 81.3% among trainees. Reporting that friends used tobacco decreased slightly in both groups. Reporting that tobacco was sold near schools remained high among trainers (96.3% to 97.5%) and increased among trainees (31.3% to 77.5%). Visibility of anti-tobacco posters in schools increased from 77.5% to 96.3% among trainers and from 65% to 97.5% among trainees (Table 9).

Table 1: Socio-demographic profile of trainer and trainee groups.

Variables	Trainer (n=80)	Trainee (n=80)
Age (in years)	14 (48.8%)	13 (13.8%)
	15 (48.8%)	14 (76.3%)
	16 (2.5%)	15 (10%)
Gender	Male: 57.5%	Male: 58.8%
	Female: 42.5%	Female: 41.3%
Religion	Hindu: 52.5%	Hindu: 66.3%
	Muslim: 47.6%	Muslim: 33.8%
Family type	Joint: 36.3%	Joint: 42.5%
	Nuclear: 63.8%	Nuclear: 57.5%

Table 2: Parental education and occupation.

Variables	Trainer (n=80)	Trainee (n=80)
Father's education	Primary: 28.8%	Primary: 46.3%
	High school: 42.5%	High school: 27.5%
	PUC: 23.8%	PUC: 26.3%
Mother's education	Primary: 37.5%	Primary: 55%
	High school: 48.8%	High school: 40%
Father's occupation	Private: 32.5%	Private: 56.3%
	Self-employed: 58.8%	Self-employed: 35%
Mother's occupation	Homemaker: 73.8%	Homemaker: 72.5%

Table 3: Knowledge scores before and after intervention.

Groups	Category (Pre)	Category (Post)	Improvement
Trainer	Poor: 2.5% Average: 78.8% Good: 18.8%	Good: 100%	Significant ($p<0.05$)
Trainee	Poor: 15% Average: 82.5% Good: 2.5%	Good: 97.5%	Significant ($p<0.05$)

Table 4: Wilcoxon test for Within-group knowledge comparison.

Groups	Pre median, (IQR)	Post median, IQR)	P value
Trainer	11 (3)	17 (2)	<0.05
Trainee	9 (4)	17 (1)	<0.05

Table 5: Mann-Whitney U test for between-group knowledge comparison.

Time	Trainee median, (IQR)	Trainer median, (IQR)	P value
Pre-test	9 (4)	11 (3)	<0.05
Post-test	17 (1)	17 (2)	0.169

Table 6: Attitude categories before and after intervention.

Groups	Negative attitude, (Pre)	Negative attitude, (Post)	P value
Trainer	18.8%	75%	<0.05
Trainee	25%	96.3%	<0.05

Table 7: Wilcoxon test for within-group attitude comparison.

Groups	Pre median, (IQR)	Post median, (IQR)	P value
Trainer	6 (1.75)	8 (1)	<0.05
Trainee	3 (2)	8 (1)	<0.05

Table 8: Mann-Whitney U test for between-group attitude comparison.

Time	Trainee median, (IQR)	Trainer median, (IQR)	P value
Pre-test	3 (4)	6 (3)	<0.05
Post-test	8 (1)	8 (2)	0.056

Table 9: Tobacco-use behaviour indicators.

Indicators	Trainer pre (%)	Trainer post (%)	Trainee pre (%)	Trainee post (%)
Ever used tobacco	6.3	2.5	3.8	1.3
Use in past 30 days	6.3	2.5	3.8	1.3
Family member uses tobacco	68.8	61.3	55	18.8
Tried to stop family member	61.3	81.3	55	81.3
Friend uses tobacco	15	12.5	22.5	15
Tobacco sold near school	96.3	97.5	31.3	77.5
Posters seen in school	77.5	96.3	65	97.5

DISCUSSION

This study evaluated the effectiveness of a CtC educational intervention in improving knowledge, attitudes, and practices regarding the health hazards of tobacco use among government school children in urban Belagavi. The findings indicate substantial and statistically significant improvements across all primary outcome domains, fulfilling the study objectives and supporting the role of peer-led approaches in adolescent health education.

Improvement in knowledge

Knowledge levels improved among trainer and trainee groups after the intervention. Trainers shifted from predominantly average levels at baseline to 100% achieving good knowledge, while trainees improved from a majority in the average and poor categories to nearly all being classified as good post-intervention. These improvements demonstrate the strong educational value of the peer-led CtC method. Similar improvements in the tobacco-related knowledge have been consistently reported in earlier studies evaluating school-based tobacco prevention programmes.[6-9] The results also align with broader literature demonstrating that interactive, structured educational sessions lead to significant cognitive gains among adolescents. More specifically, the knowledge improvements observed in this study reflect the effectiveness of CtC methods reported by Elewa and Saad, Al-Kotb and colleagues, and Banerjee et al who documented enhanced knowledge retention when children serve as health communicators and facilitators.[13-15]

Improvement in attitudes toward tobacco use

Attitude scores also improved substantially, with the median attitude score rising significantly among both groups. Trainees demonstrated notable attitudinal change, shifting from a median of 3 to 8, while trainers showed a similar improvement from 6 to 8. These findings mirror evidence from earlier interventions showing that structured educational programmes can effectively modify attitudes and reduce favourable perceptions toward tobacco use among adolescents.[6-8] Peer-led programmes appear particularly effective in shaping

social norms and reinforcing risk perception, as suggested by findings from Mohammadi et al who emphasized that adolescents may be more receptive to messages delivered by peers than by adults.[12]

Changes in tobacco-use practices and behavioural indicators

The evaluation of practice-related indicators revealed reductions in ever-tobacco use and past 30-day use in both groups. Although the baseline prevalence of tobacco use was low, the further decline following the intervention is encouraging and consistent with evidence from evaluations of school-based tobacco cessation and prevention programmes conducted in India, Pakistan, and Indonesia.[7,10,11] A particularly noteworthy result was the considerable decrease in reported family tobacco use among trainees, from 55 percent to 18.8 percent, alongside increased attempts by students to influence family members to reduce or quit tobacco use. These findings highlight the potential of CtC interventions to create a ripple effect beyond the classroom and into the home environment, consistent with earlier CtC-based studies showing that children can effectively influence household health behaviours.[13-16]

Awareness of environmental and school-level tobacco indicators also increased significantly. Students reported greater visibility of anti-tobacco posters and greater recognition of points of sale near schools after the intervention. Improved environmental awareness is a critical component of tobacco prevention and aligns with previous evaluations of school-based anti-tobacco initiatives, which found that heightened observation of contextual risk factors reinforces students' motivation to avoid tobacco.[9,18]

Overall, the present study's results strongly align with its stated objectives. Baseline assessments revealed substantial knowledge gaps and unfavourable attitudes, highlighting the need for a structured intervention. The CtC model was successfully implemented, creating a peer-driven educational pathway that resulted in significant improvements in knowledge, attitude, and practice indicators. These results correspond closely with the growing body of evidence supporting peer-led, interactive, and adolescent-friendly approaches in tobacco prevention interventions.

While the study demonstrates encouraging results, certain limitations must be acknowledged. The intervention was conducted in only two government schools within a single urban cluster, which may limit generalizability. All behavioural outcomes were based on self-report, which may be influenced by social desirability bias. Additionally, the relatively short duration between the intervention and post-test assessment prevents conclusions about long-term retention of knowledge or sustained behaviour change. Despite these limitations, the consistent and significant improvements observed among both trainers and trainees provide compelling evidence that the CtC approach is an effective educational strategy for tobacco prevention among adolescents.

CONCLUSION

In conclusion, the findings of this study reinforce existing evidence demonstrating that school-based and peer-led interventions are effective in enhancing adolescents' knowledge, modifying attitudes, and promoting healthier practices related to tobacco use. The CtC approach offers a promising, scalable, and engaging method of health education that can be integrated into school health programmes. Future research with larger sample sizes, longer follow-up periods, and integration of additional interactive methods such as digital media may further strengthen the evidence base and support sustained behavioural change.

ACKNOWLEDGEMENTS

Authors would like to thank to Dr. Aziz Arbar and Dr. Ashwini Narasannavar for valuable insights, encouragement, and contributions in shaping this work.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee Ref No. MDC/JNMCIEC/323.

REFERENCES

1. Peirson L, Ali MU, Kenny M, Raina P, Sherifali D. Interventions for prevention and treatment of tobacco smoking in school-aged children and adolescents: A systematic review and meta-analysis. Preventive Med. 2016;85:20-31.
2. Tiwari RV, Megalamanegowdru J, Gupta A, Agrawal A, Parakh A, Pagaria S, et al. Knowledge, Attitude and Practice of Tobacco Use and Its Impact on Oral Health Status of 12 and 15 Year-Old School Children of Chhattisgarh, India. Asian Pacific J Cancer Prevent. 2015;15(23):10129-35.
3. Singh S, Vijayakumar N, Priyadarshini H, Jain M. Tobacco use among high school children in Bangalore, India: A study of knowledge, attitude and practice. Indian J Cancer. 2015;52(4):690.
4. Kumar P, Shanmugam B, Jothikaran TAJ, Ezhumalai S. Perception of Tobacco Use among School-Going Early Adolescent Children in Udupi District: A Cross-sectional Study. J Psychiat Spectrum. 2023;2(2):80-7.
5. Nguyen TH, Nguyen TK, Kim BG, Hoang VM, Phan TH, Doan TH, et al. Knowledge and Attitude Towards Tobacco Smoking among 13-15 Year-Old School Children in Viet Nam-Findings from GYTS 2014. Asian Pacific J Cancer Prevent. 2016;17(1):37-42.

6. Khubchandani J, Sharma M, Huston D, Tahiliani J. Tobacco use related attitudes and behaviors in Indian Adolescents: association with school-based prevention education. Health Promot Perspect. 2017;7(3):128-33.
7. Jayakrishnan R, Geetha S, Mohanan Nair JKKP, Thomas G, Sebastian P. Tobacco and Alcohol Use and the Impact of School Based Antitobacco Education for Knowledge Enhancement among Adolescent Students of Rural Kerala, India. J Addict. 2016;2016:1-8.
8. Ghate NP, Vaidya VM, Joshi VC. Evaluation of PACE (Prevent Addictions through Children's Education) Tobacco Awareness Program for School Children in Pune and Mumbai. Indian J Pediatr. 2017;84(2):156-7.
9. Rao A, Mithra P, Shenoy R, Rungta N. Effectiveness of a School-Based 'Tobacco Free' Intervention on Adolescents' Knowledge and Exposure to Second Hand Tobacco Smoke - A Multiphase Study. Asian Pac J Cancer Prev. 2019;20(12):3533-7.
10. Tahlil T, Woodman RJ, Coveney J, Ward PR. The impact of education programs on smoking prevention: a randomized controlled trial among 11 to 14 year olds in Aceh, Indonesia. BMC Public Health. 2013;13(1):367.
11. Rozi S, Zahid N, Roome T, Lakhdir MPA, Sawani S, Razzak A, et al. Effectiveness of a School Based Smokeless Tobacco Intervention: A Cluster Randomized Trial. J Community Health. 2019;44(6):1098-110.
12. Mohammadi M, Ghaleiha A, Rahnama R. Effectiveness of a Peer-Led Behavioral Intervention Program on Tobacco Use-Related Knowledge, Attitude, Normative Beliefs, and Intention to Smoke among Adolescents at Iranian Public High Schools. Int J Prevent Med. 2019;10(1):111.
13. Elewa AAA, Saad AM. Effect of child to child approach educational method on knowledge and practices of selected first aid measures among primary school children. JNEP. 2017;8(1):69.
14. Al-Kotb Mohamed H, Abo Elsoud MS. Effect of Child-to-Child Approachon Practices of Primary School Children Regarding Epileptic Seizures First Aids. MLU. 2021;21(2):588-97.
15. Banerjee B, Banerjee R, Ingle GK, Mishra P, Sharma N, Garg S. Effectiveness of Child-To-Child Approach in Preventing Unintentional Childhood Injuries and Their Consequences: A Non-Randomized Cluster-Controlled Trial. Indian Pediatr. 2021;58(6):542-7.
16. Sajjan J, Kasturiba B, Naik R, Bharati P. Impact of child to child nutrition education intervention on nutrition knowledge scores and hemoglobin status of rural adolescent girls. Karnataka J Agricultural Sci. 2012;24(4):513-5.
17. Fiellin LE, Hieftje K, Pendergrass T, Liu M, Tindle H, Krishnan-Sarin S, et al. A Videogame Intervention for Tobacco Product Use Prevention in Adolescents. J Adolescent Health. 2018;62(2):S84-5.
18. Hodder RK, Daly J, Freund M, Bowman J, Hazell T, Wiggers J. A school-based resilience intervention to decrease tobacco, alcohol and marijuana use in high school students. BMC Public Health. 2011;11(1):722.

Cite this article as: Revagoud K, Reddy CV, Patil D, Sarawade R. Impact of a child-to-child programme on knowledge, attitude and practices regarding tobacco hazards among government school children in urban Belagavi: an interventional study. Int J Community Med Public Health 2026;13:168-74.