Innovative Journal of Medical and Healthcare Research (IJMHR)
Volume-2 Issue-2 March-2025

Assessment Of Knowledge Attitude And Practice Among Mothers To Control Acute Respiratory Infection In Children Less Than 5 Years In Chitapur City

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ABSTRACT

Acute respiratory tract infections (ARIs) constitute the major causes of mortality and morbidity among under-five children of the developing world. The ARI under five-year age group children is becoming challenge for health system in urban and rural areas. In current life style due to various socioeconomic and environmental conditions. ARI has become crucial as it happens quickly and without much warning. It is often caused by a disease or injury that affects children breathing, such as pneumonia, opioid overdose, stroke, or a lung or spinal cord injury. Parent's unawareness, a negligence and inadequate medical facilities in rural areas adversely affects children health. Considering these circumstances, the present study was conducted to emphasis assessment of knowledge, attitude and practice among mothers to control acute respiratory infection in children less than 5 years. Mother's are to be educated about ARI, their consequences and protection of children from ARI and treatment of there. The study revealed that out of 714 participants, 44.70% were males and 55.30% were females. Most of the participants, 62.50% were having lower socioeconomic condition. Maximum fathers around 28.20% had taken primary education. Occupation wise 74.10 % were of labor class people who were staying in Kaccha house. Such kind of residents were 86.10% out of total surveyed crowd. We observed that mostly children were delivered in Government hospital in Chitapur around 41.60%, out of 714 children 707 births were attended by qualified persons and 92.20% were fully vaccinated the parameters used for this study resulted into thorough knowledge about various attributes and causes of ARI. Knowledge sharing about ARI, preventive measures by parents and proper treatment thereof is required for children's well-being.

Keywords: Acute Respiratory Tract (ARI), Medical Facilities, Environmental Conditions, Kaccha House.

I. INTRODUCTION

A severe acute respiratory infection (SARI) is defined by the World Health Organisation (WHO) as a case of acute respiratory infection in which hospitalisation, coughing, fever, and symptoms within 10 days of presentation are present.

Any inflammation of the respiratory system, from the nasal passages to the alveoli, is known as an acute respiratory infection.

1.1 Causes of ARI

ARIs in children have a significant impact on daily living, particularly in areas where access to medical treatment is limited or nonexistent. In both developing and wealthy nations, acute respiratory tract infections are among the leading causes of death and disability in children less than five years old. Inflammation of the respiratory system, ranging from the nasal passages to the alveoli, is known as an acute respiratory infection (URI). Symptoms may manifest in a variety of ways.

1.2 Types

The two main types of acute respiratory infections (ARI) are those that affect the upper or lower respiratory tracts, respectively. Infections in the upper respiratory tract are more prevalent than those of the lower respiratory tract. In both developed and developing nations, children experience five episodes of acute respiratory illness (ARI) every year. Approximately 3.9 million people die from ARI globally, with pneumonia accounting for 90% of these deaths. A community-based study found that ARI accounted for 70% of childhood morbidities in children younger than five years old.

A number of variables increase the likelihood that a child would get a respiratory infection. These include parental illiteracy, poverty, overcrowding, hunger, not breastfeeding, prelacteal meals, incomplete vaccination, indoor air pollution, and early weaning.

1.3 RISK FACTORS

There are more than 200 different types of viruses that may cause the common cold, the most frequent of which being adenoviruses, human coronaviruses, and rhinoviruses. Symptoms include a stuffy or runny nose, fever, headaches, coughing, a sore throat, sneezing, and nasal congestion, pharynxitis, or sinusitis. The causative agent of LRTI differs in emerging nations, yet the condition is more common in developed nations overall. Both the selection of effective antibiotics and the selection of empirical treatments have been affected by the rise in antibiotic resistance. Staphylococcus aureus, Klebsiella pneumoniae, Haemophilus influenzae, Streptococcus pneumoniae, and Haemophilus influenzae are among the other bacteria that may cause LRTIs.

There is a significant monetary cost associated with Acute Respiratory Infection (ARI), which is a major cause of death and disability among children. Particularly in underdeveloped nations, ARI control is a significant public health concern. The most common childhood ailments, such as urinary tract infections (URTIs), are routinely treated with antibiotics, even though they are sometimes overused. Mistakes in antibiotic selection, insufficient doses, and overtreatment are consequences of antibiotic self-medication, a serious problem on a worldwide scale. A combination of public education and the expertise of healthcare providers is necessary to reduce antibiotic usage.

In underdeveloped nations, children often die from respiratory illnesses such acute respiratory infections (ARI). Out of the 15 million child deaths that occur every year, 4 million are caused by acute respiratory infections (ARIs), with 7 out of 10 of those fatalities happening in children under the age of 5. A staggering 75% of ARI fatalities in underdeveloped nations are caused by pneumonias. Bacterial pneumonia accounts for 90% of the approximately 3.9 million fatalities caused by acute respiratory infections (ARI) globally. Most of the avoidable fatalities in India's under-5 population are caused by ARI, which accounts for 15-30% of all deaths in this age group. In poor nations, ARI is responsible for as many as thirteen percent of paediatric ward inpatient mortality. About 238 million cases of acute respiratory infections (ARI) occur annually; the majority of these cases are minor and resolve on their own. In order to control ARI, which causes 30–50% of all doctor’s visits and 20–40% of all hospitalisations, it is essential to implement effective early treatment and encourage health-seeking behaviour.

1.4 IMPORTANCE OF KAP IN ARI

The mother's understanding and perspective on these illnesses greatly impact the child's well-being. In almost every culture, the mother plays a key role in caring for her child. Therefore, a child's health and survival are closely correlated with the mother's level of knowledge, attitude, and health behaviours. The majority of acute respiratory illness morbidity is treatable with at-home care. Health education that covers the root causes, preventative strategies, and management techniques may help bridge the gap between society and health care.

1.5 Role of pharmacist in ARI

Because of their proximity to patients and extensive knowledge of medications, chemists are in a prime position to diagnose common health issues, counsel patients on how to manage them, and prescribe the best course of treatment. In jurisdictions where antibiotics can be purchased over-the-counter without a doctor's prescription and consumer demand is high, it is especially important to remind patients that there is no treatment for viral infections like the common cold or influenza and that antibiotics are not a part of the management of these conditions. It is the chemist's responsibility to encourage the prudent, reasonable, and safe use of medications.

Seasonal flu shots and other immunisations should be available from pharmacists, and pharmacists should also give them. By educating patients on allergic rhinitis and its proper management, chemists may help these patients optimise their treatment, understand how to use their devices correctly, and reduce the risk of comorbid asthma. At last, chemists are able to determine whether patients need to see a specialist (e.g., a doctor or an optometrist). While both rich and developing nations have similar rates of incidence, the former has ten to fifty

times greater rates of cause-specific death from ARI.

Urban slums, according to some research, have a much more severe ARI issue than rural areas. Acute respiratory infections (ARIs) have emerged as a serious threat to India's public health. Therefore, the purpose of this research was to determine if health education increased parents' awareness of the signs and symptoms of acute respiratory infections in children less than five years old. Overcrowding, industrialisation, sociocultural values, antibiotic abuse and misuse, inadequate housing, inadequate nutrition, indoor air pollution (including parental smoking), inadequate ventilation, inadequate health care, and general lack of knowledge are all contributing factors.

When compared to high-income nations, low- and middle-income nations bear a disproportionate share of the burden associated with ARI incidence and prevalence. Worldwide, around 2.1 million children under the age of five died each year from ARI-related causes (not including those caused by measles, pertussis, or newborn mortality); this accounts for approximately 20% of all paediatric fatalities, according to the World Health Organisation. Roughly 10.8 million youngsters succumb to ARI annually.

Many children die at home, hence the percentage of community deaths attributable to ARI is much larger.

Among acute respiratory illnesses, pneumonia poses the greatest risk if left untreated.

II. OBJECTIVES

2.1 PRIMARY OBJECTIVES-

- The aim of the research was to evaluate the level of understanding, perspective, and behaviour of Chitapur mothers about ARI in children less than five years old.

2.2 SECONDARY OBJECTIVES-

- Determine the causes of acute respiratory distress in children less than five years old.
- In order to compile the socioeconomic characteristics of the participating parents.
- To educate people on how to avoid getting ARI and what medications are available for treatment.

III. REVIEW OF LITERATURE

After obtaining informed permission, a cross-sectional research was conducted on 120 parents of children under the age of five. The duration of the study was three months. After collecting information on knowledge of acute respiratory infections and providing health education on the topic using flip charts, the same questionnaire was used to provide a post-test assessment two weeks later, with data analysed using SPSSV20 and Microsoft Excel. After participating in health education initiatives, the majority of parents' knowledge score increased considerably.

At Barbanki, researchers looked at cases of lower respiratory tract infections. This study included around 75 participants of both sexes. The patients came from the following areas: the intensive care unit (ICU), the outpatient department (OPD), and the inpatient department (IPD). Of the 75 cases, 42 were male and 33 were female. A variety of bacteria were found in the samples, including Pseudomonas species (35%), Pseudomonas aeruginosa (24%), acinetobacter species (16%), Proteus species (5%), klebsiella species (4%), Escherichia coli (3%), EnterobacterAerogenes (6%), and Streptococcus pneumonia (7%). A substantial change was observed ($P< 0.05$). There were 28 patients in the intensive care unit, 30 in the outpatient department, and 37 in the outpatient clinic. There were 16 cases of broncho alveolar lavage, 52 cases of sputum, 4 cases of stomach aspirate, 2 cases of ET tube, and 1 instance of endotracheal aspirate. A substantial change was observed ($P< 0.05$).

Estimating the prevalence of ARI and chosen related variables was the goal of the research. In both urban and rural parts of Puducherry, India, researchers performed a cross-sectional study based on community members' experiences. In order to better understand the prevalence of ARI and its related variables, we surveyed 509 parents of children less than five years old. Urban regions had a prevalence of 63.7% and rural areas 53.7% of ARI, for a total prevalence rate of 59.1%. According to the authors, ARI is rather common, especially in cities.

One way to lessen the impact of ARI on the community is to make people's living situations better.

Rural areas of Maharashtra were the sites of the case control research, which Annually, almost 12 million children, including many in their first year of life, lose their lives to severe respiratory illnesses before they turn five. Acute respiratory tract infections, starvation, and diarrhoeal disorders are among the many paediatric illnesses. The way a mother feels and what she knows about these conditions greatly impact her child's health. In almost every culture, the mother plays a key role in raising her children. Therefore, a child's health and survival are strongly related to the mother's health literacy, attitude, and behaviours. Examine parental and child understanding, sentiment, and action (KAP) on acute respiratory illnesses. The KAP was administered to their moms in the comfort of their own homes using redesigned and pilot-tested questions. Children and their moms were measured using a scoring system that was created specifically for this purpose. The well-being and level of education of a woman greatly impact her child's health. Thus, maternal education and health behaviour change regarding acute respiratory disease has a direct impact on infant vitality and health.

Research on ARI in children less than five years old was conducted in Faisalabad by the authors. A cross-sectional survey was used in the research, which was carried out at the paediatrics department at Faisalabad. The study lasted for thirteen months. For the sake of better comprehension, the survey was conducted in English and then translated into Urdu. The interviewer distributed the questionnaire. The moms were interrogated by researchers and two in-house doctors. The research included 335 kids in all. The prevalence of ARI was 228 cases out of 335 children, or 68%. The children's average age was 20 months with a standard deviation of 17, and their average birth weight was 2.7 kg with a standard deviation of 1.8. The majority of women chose to seek medical attention for their symptoms, with the most frequent symptom being a cough (n=303, 40%). The symptoms were most severe during the winter (n=255, 87%). Dust was the most common cause that made their symptoms worse (n=174, 81%). Pneumonia was the most common consequence (n=135, 83%). Among the medications taken most frequently, 192 (or 58% of the total) reported using paracetamol (n=117, or 42% of the total). The research found that moms had a strong understanding of ARI symptoms, environmental variables that make them worse, aggravating factors, and consequences. With early contact with a trained medical practitioner, their approach towards ARI was right. Mothers' knowledge, attitude, and practice are all positively impacted by a higher literacy rate.

IV. METHODOLOGY

STUDY SITE- Study was conducted at Chitapur of Kalaburgi district.

STUDY DURATION- The study was conducted for a period of 6 months**(March 2023- August 2023)**

STUDY DESIGN- "A CASE-CONTROL STUDY"

STUDY CRITERIA- Following the collection of informed permission from participating parents in a properly prepared form in their regional/understandable language, the following inclusion and exclusion criteria were considered for the study's execution.

INCLUSION CRITERIA

- Moms who choose to take part in the research themselves.
- Expectant moms with a kid younger than five
- Women seeking treatment for a variety of medical issues sometimes visit the provide answer.
- They were accompanied by women who had at least one kid under the age of five.

EXCLUSION CRITERIA

- When asked questions, mothers fail to understand. Mothers residing in the vicinity.
- The mother disinterested in taking part.

- Women whose children are five years old and older

STUDY MATERIALS-

The current research made use of the following study resources.

ETHICAL COMMITTEE APPROVAL-(ANNEXURE-1)

The HKE Matoshree Taradevirampure Institute of Pharmaceutical Science in Kalaburagi granted ethical approval before the trial began.

PERMISSION LETTER-(ANNEXURE-2)

The deputy director of the Kalaburagi municipal department of women and child welfare gave the go-ahead.

PARTICIPANT INFORMED CONSENT FORM (ANNEXURE-3)

Prior to the participant's enrolment, an informed consent form was produced and acquired from them, taking into account the study's requirements.

PARTICIPANTS DATA COLLECTION FORM- (ANNEXURE-4)

Article reviews and primary sources were used to compile the participant data collecting form, which asks for basic personal information such name, age, gender, education level, occupation, and mailing address.

QUESTIONNAIRES- (ANNEXURE-5)

In order to examine mothers' knowledge, attitude, and practice in controlling ARI in their children, a variety of well constructed questionnaires were developed, drawing from both original and review papers.

PATIENT INFORMATION LEAFLETS- (ANNEXURE-6)

The World Health Organization's recommendations and the National Health Formulary were consulted in the development of appropriately designed patient information booklets. These leaflets provide details on the proper disposal of unused and expired medications.

DEMONSTRATING WITH EDUCATIONAL VIDEOS-(ANNEXURE-7)

The purpose of this self-produced and narrated instructional film was to inform mothers about acute respiratory infections, how to treat their children, and the importance of a healthy lifestyle for their children. and the World Health Organization's (WHO) web films were used.

ASSESSMENT OF KNOWLEDGE ATTITUDE AND PRACTICE AMONG MOTHER'S TO CONTROL ACUTE RESPIRATORY INFECTION IN CHILDREN LESS THEN 5 YEARS IN CHITAPUR CITY- (ANNEXURE-8)

STUDY PROCEDURE:

Several neighbourhoods in Chitapur city were randomly assigned to participate in the case control study, which lasted six months. Following a preliminary survey that showed an increase in the city's reported instances of ARI, the study was approved by the relevant institutional bodies and put into motion.

The questionnaire was translated from English to Kannada so that participants could understand it better and

provide their informed consent.

We divided the public into two groups to find out whether KAP scores were significantly different: one group got education and a questionnaire, while the other group got patient information pamphlets and questionnaires.

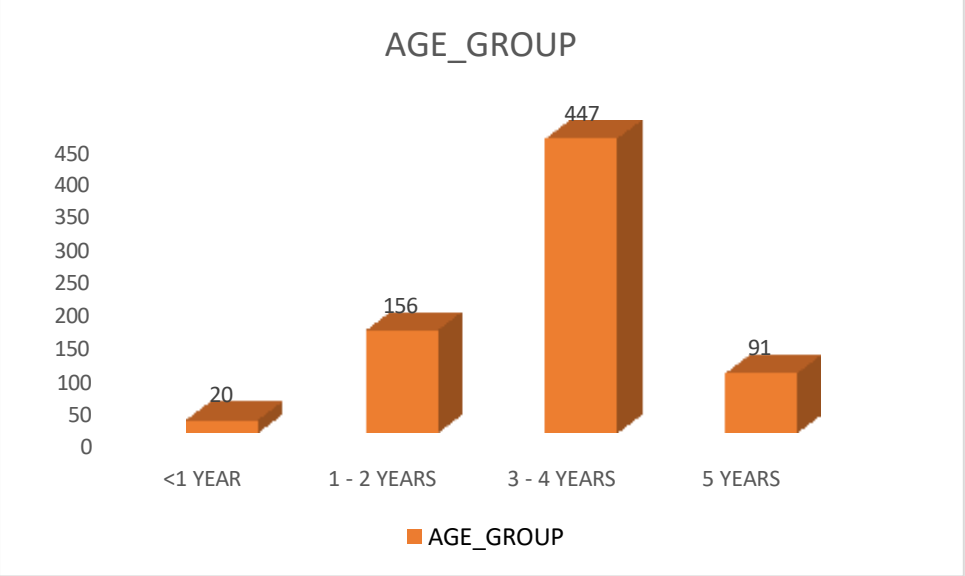
Researchers administered the same questionnaire to both groups after a predetermined period of time (one month) in order to compare the test groups' pre- and post-KAP scores. To evaluate whether the experimental and control groups differed significantly, we ran a statistical analysis on the collected data. The collected data was entered using SPSS statistical software, version 21, and Excel spreadsheets. For continuous data, we utilised the mean standard deviation; for categorical data, we used the frequency and percentage. We used p-value analyses, chi-square tests, and student T-tests to find out how much of an effect socioeconomic status, profession, and degree of education had.

RESULT AND DISCUSSION

TABLE 1- AGE GROUPS OF SUBJECTS INCLUDIED IN THE STUDY.

AGE_GROUP	Frequency	Percent
<1 YEAR	20	2.8
1 - 2 YEARS	156	21.8
3 - 4 YEARS	447	62.6
5 YEARS	91	12.7
Total	714	100

FIGURE 1. AGE GROUPS OF SUBJECTS INCLUDIED IN THE STUDY



In our study, about 714 subjects were enrolled. Out of which 447(62.6%) highest number of subjects were in the age group of 3-4 years, 156(21.8%) subjects were seen in the age group of 1-2 years, 91(12.7%) were seen in the age group of 5 years, and 20(2.8%) lowest subjects were seen in the age group below 1 years. The population was seen to be more in the age group of 3-4 years

TABLE NO 2- DETAILS OF BIRTH TERM OF TOTAL POPULATION

TERM OF CHILD (FULL, PRE)	Frequency	Percent
Full	684	95.8
Pre	30	4.2
Total	714	100

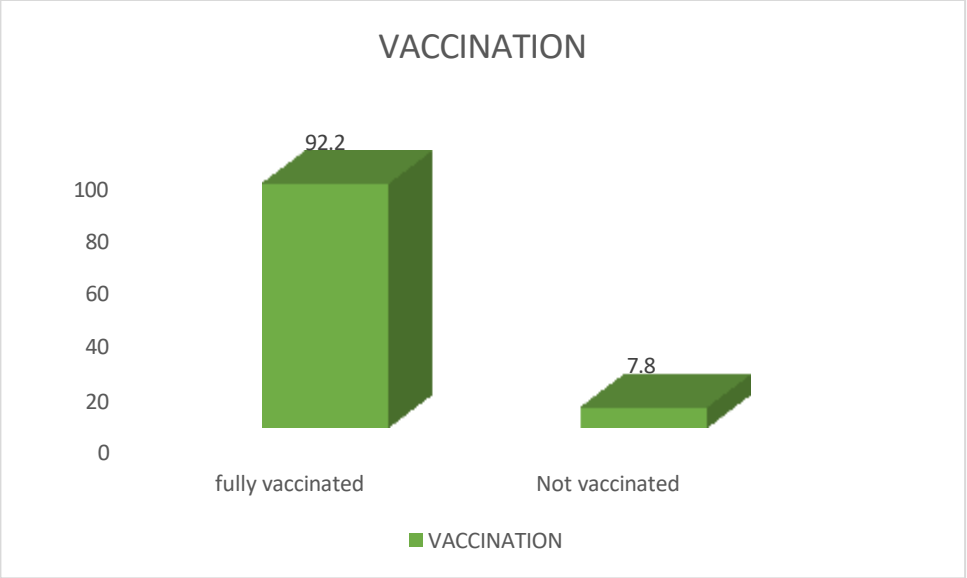
FIGURE NO 2- DETAILS OF BIRTH TERM OF TOTAL POPULATION

Out of 714 children enrolled in studies, we observed that 684 (95.8%) were born after full term of pregnancy whereas 30 (4.2%) were pre mature births. This indicates that full term births were higher than pre mature term.The results were similar to the work carried out byDrJaveriaGauharetal. (2019)

TABLE NO 3- DETAILS OF VACCINATION OF TOTAL POPULATION

VACCINATION	Frequency	Percent
fully vaccinated	658	92.2
Not vaccinated	56	7.8
Total	714	100

FIGURE NO 3- DETAILS OF VACCINATION OF TOTAL POPULATION

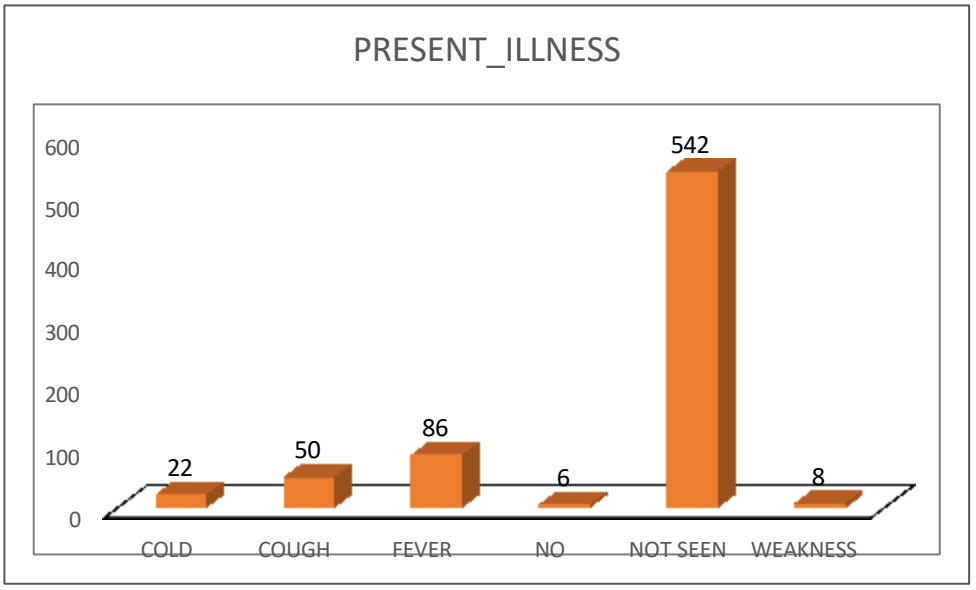


Of the 714 participants in our research, 658 (92.2%) were completely immunised and 56 (7.8%) were not. This led us to the conclusion that there are more fully vaccinated youngsters. Findings were consistent with those of Dr. Javeria Gauharetal's previous research in the year 2019

TABLE NO 4- DETAILS OF PRESENT HEALTH CONDITION OF TOTAL POPULATION

PRESENT_ILLNESS	Frequency	Percent
COLD	22	3.1
COUGH	50	7
FEVER	86	12.1
NO	6	0.8
NOT SEEN	542	75.9
WEAKNESS	8	1.1
Total	714	100

FIGURE NO 4- DETAILS OF PRESENT HEALTH CONDITION OF TOTAL POPULATION

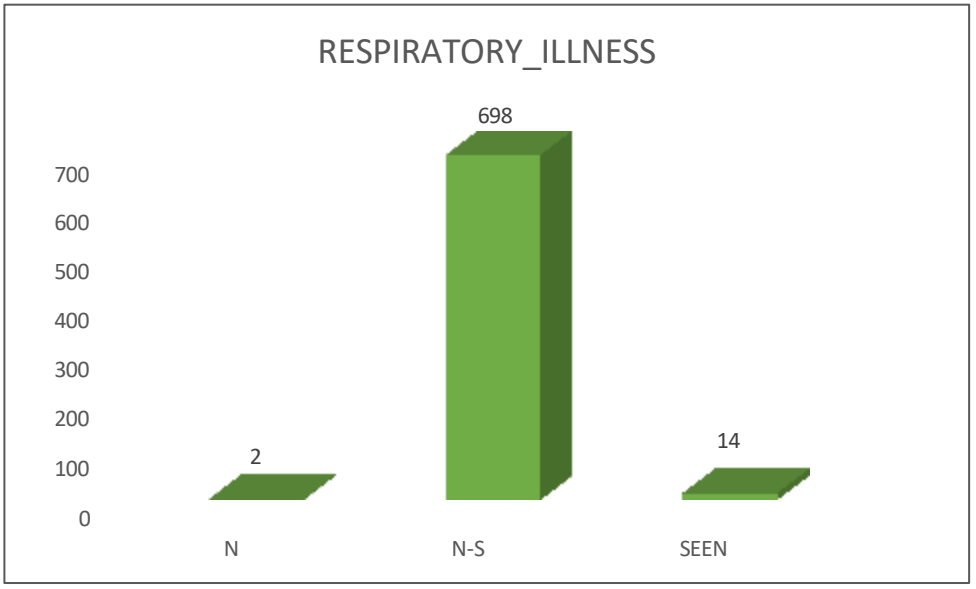


Out of 714 individuals, 542 (or 75.9%) did not show any signs of illness. In contrast, 79 (11.1%) had fever, 50 (7%) had cough, 22 (3.1%) had cold, 8 (1.1%) had weakness, 7 (1.0%) had cold and fever, and 6 (0.8%) had no infections whatsoever.

TABLE NO 5- DETAILS OF RESPIRATORY ILLNESS OF TOTAL POPULATION

RESPIRATORY_ILLNESS	Frequency	Percent
No	2	0.3
Not Seen	698	97.8
SEEN	14	2
Total	714	100

FIGURE NO 5- DETAILS OF RESPIRATORY ILLNESS OF TOTAL POPULATION

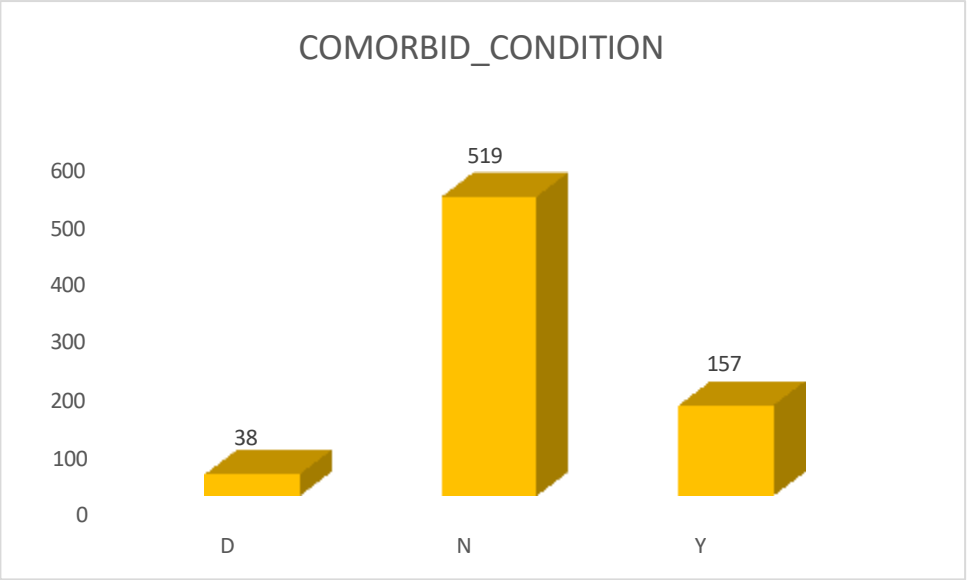


The results of our research on respiratory sickness in 714 people showed that 698 of them (97.8%) had no noticeable symptoms, 14 people (2%) had respiratory illness, and 2 people (0.3%) were completely healthy.

TABLE NO 6- DETAILS OF COMORBID CONDITION OF TOTAL POPULATION

COMORBID_CONDITION	Frequency	Percent
Don't know	38	5.3
No	519	72.7
Yes	157	22
Total	714	100

FIGURE NO 6- DETAILS OF COMORBID CONDITION OF TOTAL POPULATION

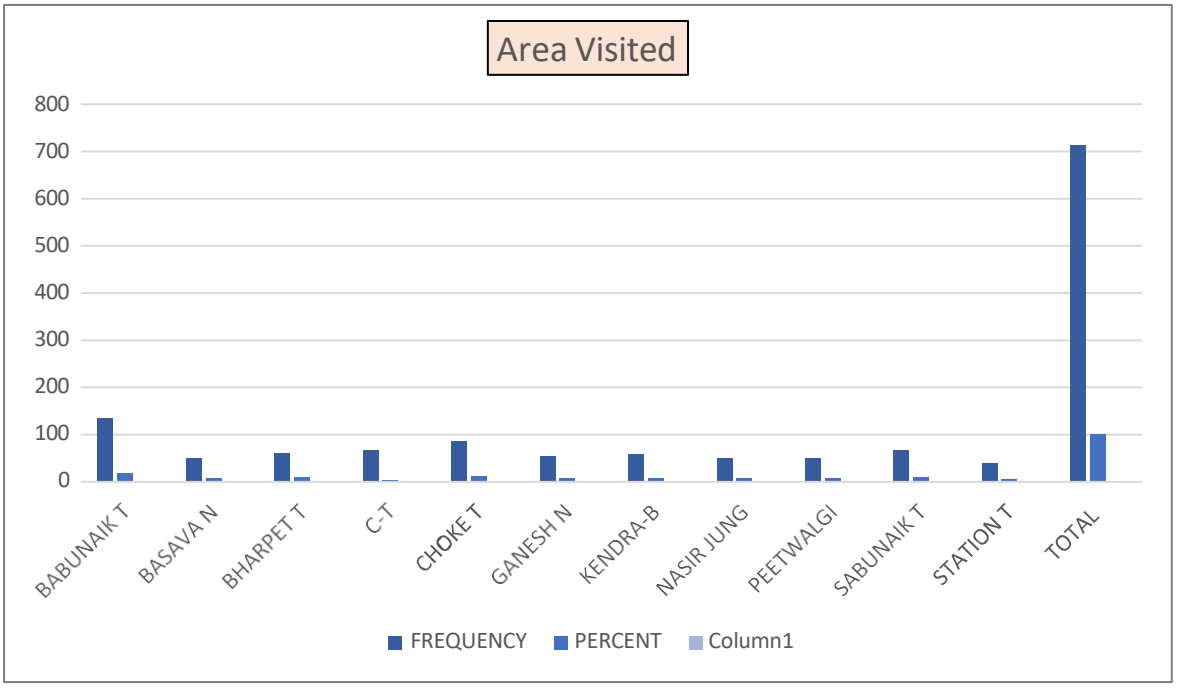


In our study of 714 people, we found that 519 (71.7%) did not have any co-morbid diseases, 157 (22%), had a history of comorbid conditions, and 38 (5.3%) were unsure about their comorbid history.

TABLE NO-7 DETAILS ABOUT THE AREAS OF CHITAPUR ANGANWADI

ADDRESS	Frequency	Percent
BabunaikTanda	134	18.8
Basavanagar	50	7
BharpetTanda	61	8.5
ChatrunaikTanda	67	9.4
Choke Tanda	85	11.9
Ganeshnagar	54	7.6
Kendra bank	58	8.1
Nasir jung	49	6.9
Peetwalgi	49	6.8
SabbunaikTanda	67	9.4
Station Tanda	40	5.6
Total	714	100

FIGURE 7 - DETAILS ABOUT THE AREA VISITED IN CHITAPUR



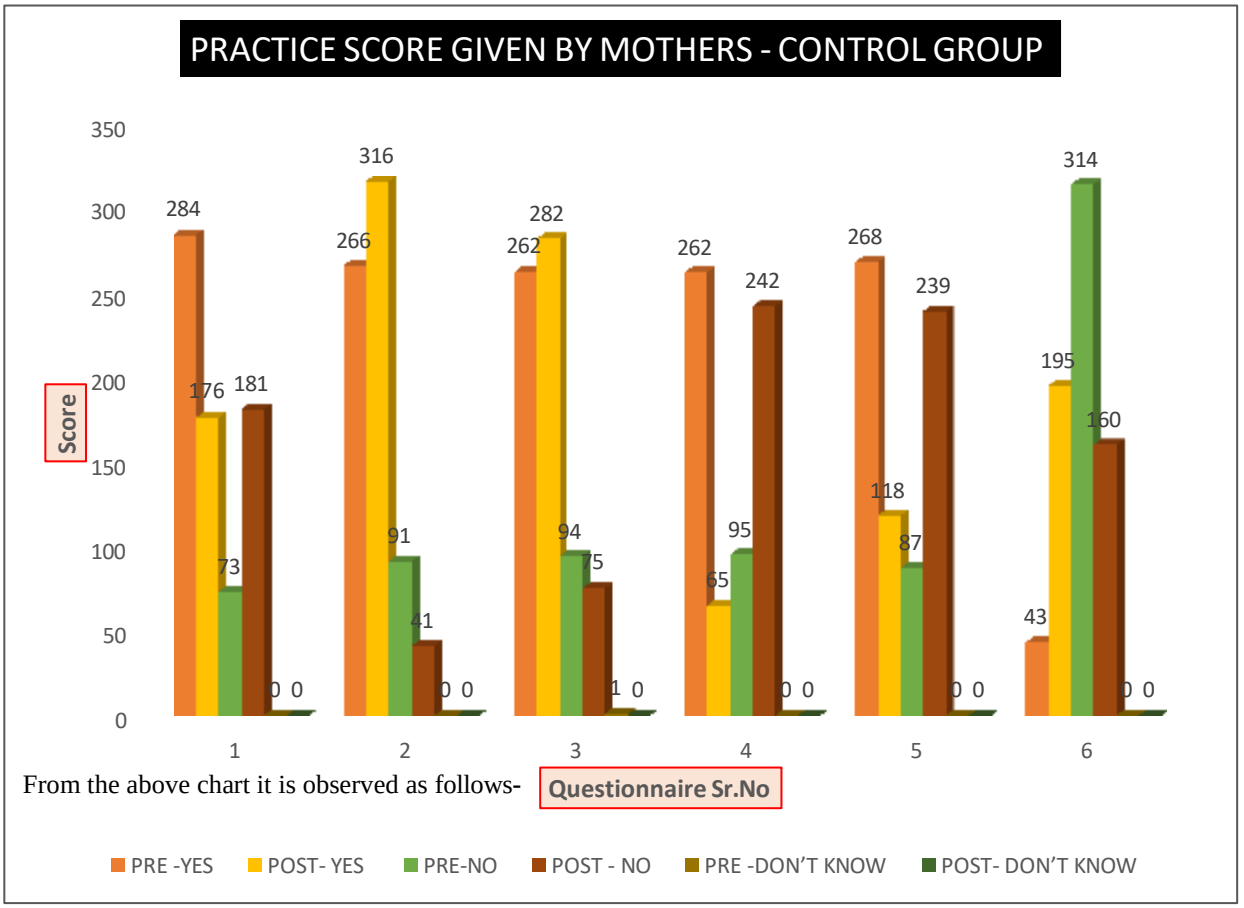
In our survey we have covered Anganwadi of chitapur most of the population of children were found in the Tanda areas of chitapurtaluka. The more children were found in Babu- naikTanda 134 (18.8%) Basavanagar 50 (7%) BharpetTanda 61 (8.5%) ChatrunaikTanda 67
(9.4%) ChokeTanda 85 (11.9%) Ganesh nagar 54 (7.6%) Kendra bank 58 (8.1%) Nasir Jung (6.8%) Peetwalgi 49 (6.8%) Sabbunaiktanda 67 (9.4%) Station tanda 40 (5.6%) and the total no of 714 parents present in the survey. Which shows that highest children‟s population were from babunaiktanda is 134, medium were from choke

tanda 85 and the lowest were from station tanda.

TABLE NO 8- DETAILS OF PRACTICE SCORE GIVEN BY THE MOTHERS IN THE CONTROL-GROUP

SL. NO	QUESTIONNAIRES	PRE- CONTROL			POST-CONTROL		
		YES	NO	DON'T KNOW	YES	NO	DON'T KNOW
1	Did you had any illness/symptoms in the last month?	284	73	0	176	181	0
	PERCENTAGE (%)	79.55%	20.44%	0%	49.29%	50.70%	0%
2	Did you take any precaution/treatment for the illness you have experienced in last month?	266	91	0	316	41	0
	PERCENTAGE (%)	74.50%	25.49%	0%	88.51%	11.48%	0%
3	Did you use self-medication?	262	94	1	282	75	0
	PERCENTAGE (%)	73.38%	26.33%	0.28%	78.99%	21.08%	0%
4	Did you take antibiotics to prevent diseases (such as common cold) in the past?	262	95	0	65	242	0
	PERCENTAGE (%)	73.38%	26.61%	0%	18.20%	81.79%	0%
5	Did you have habit of self-medications in sore- throat, cough, fever?	268	87	0	118	239	0
	PERCENTAGE (%)	75.07%	24.92%	0%	33.05	66.94%	0%
6	Do you use otc medication?	43	314	0	195	160	0
	PERCENTAGE (%)	12.04%	87.95%	0%	54.62%	44.81%	0%

FIGURE NO 8- DETAILS OF PRACTICE SCORE GIVEN BY THE MOTHERS IN THE - CONTROL GROUP



From the above chart it is observed as follows-

- Treatments and medicine - self-medication or usage of over-the-counter medication in the control group were surveyed during the most recent sickness that mothers had around a month ago. There were 357 moms in both the control group and the intervention group before and after the intervention, respectively.
- We enquired about any recent illnesses or symptoms during the pre-intervention assessment. A total of 284 respondents (or 79.55%) said that they experienced symptoms over the last month, whereas 73 respondents (or 20.44% of the total) indicated that they were symptom-free.
- There was a shift in the score after the intervention, with 181(50.70%) going negative and 176(49.29%) becoming positive.
- Additionally, we enquired about the measures and treatments implemented in response to last month's sickness. Among those who were known to have received therapy prior to the intervention, 266 (74.50%) had really done so, whereas 91 (25.49%) had not.
- After the intervention, 316 people (88.51%) got the medical attention they needed for the sickness they had in the previous month, whereas 41 people (11.48%) did not. Consequently, being conscious is crucial.
- When it came to self-medication, 73.38 percent were utilising it, 26.33 percent were not, and 0.28 percent were unaware that it was an option.
- After the intervention, 75 people (or 21.08 percent) ceased self-medicating, whereas 282 people (or 78.99%) continued to do so.
- We found that out of the whole population, 262 (73.38%) were taking antibiotics for the prevention of common colds and other illnesses, whereas 95 (26.61%) were not.
- After the intervention, the previous score was adjusted to reflect that 242 individuals (81.79%) had discontinued antibiotic usage and 65 individuals (18.20%) were still taking them.
- Many persons were seen to self-medicate when they experienced a sore throat, cough, or fever.
- Two hundred sixty-eight people (75.07%) reported engaging in this behaviour, whereas eighty-seven

(24.92%) said they did not.

- A total of 239 people (or 66.94%) did not begin self-medicating after the intervention, whereas 118 people (or 33.05%) had begun doing so.
- In addition to questions concerning self-medication, we asked about over-the-counter medicine, to which 43 people (12.04%) responded positively, meaning they were using it, whereas 314 people (87.95%) said they weren't.
- A total of 195 people (or 54.62%) began using over-the-counter medicine after the intervention, whereas only 160 people (or 44.81%) continued to use their prescription drugs.

TABLE NO 9 - DETAILS OF KNOWLEDGE SCORES IN PRE AND POST INTERVENTION.

Details of Knowledge Assessment					
Assessmet	**Group**	**PRE (MEAN±SD)**	**POST (MEAN± SD)**	**PAIRED T-TEST**	**P-VALUE**
Knowlede	**TEST Group**	**1.83±1.11**	**3.04±0.32**	**-20.068**	**0.0001**
	Control Group	**1.76±1.14**	**4.31±.94**	**-36.912**	**0.021**

TEST GROUP

A mean score of 1.83 and a standard value of 1.11 were recorded for the test group prior to the intervention in this research. The mean score was 3.04 and the standard value was 0.32 after the intervention, indicating an improvement over the pre-intervention values. The t-value is -20.068 and the P-value is 0.0001, indicating that it is very significant from a statistical standpoint.

CONTROL GROUP

In this research, the control group had a mean score of 1.76 and a standard value of 1.14 before the intervention. Following the chemist's intervention, the data showed a marked improvement, with a mean score of 4.31 and a standard value of 0.94. A statistically significant T-value of -36.912 and a p-value of 0.021 were also recorded.

TABLE NO 10- DETAILS OF ATTITUDE SCORES IN PRE AND POST INTERVENTION.

Details of Attitude Assessment					
Assessment	**Group**	**PRE (MEAN±SD)**	**POST (MEAN±SD)**	**PAIRED T-TEST**	**P-VALUE**
Attitude	**TEST Group**	**3.36±2.07**	**5.81±0.65**	**-21.215**	**0.0001**
	Control Group	**4.26±1.71**	**5.67±1.01**	**-13.559**	**0.0001**

TEST GROUP

In the current research, the test group had a mean score of 3.36 and a standard value of 2.07 before the intervention. There was an improvement in the values after the intervention, with a standard value of 0.65 and a mean score of 5.81. The results are statistically significant; the T-value is -21.215 and the P-value is 0.0001..

CONTROL GROUP

In this investigation, a control group, a mean score of 4.26 and a standard value of 1.71 were recorded before the intervention. By the end of the intervention, the values had improved to a mean of 5.67 and a standard deviation of 1.01. With a T-value of -13.559 and a P-value of 0.0001, this result is considered very significant statistically.

V. CONCLUSION

Inflammation of the respiratory tract, ranging from the nose to the alveoli, is the hallmark of acute respiratory infections (ARIs), which may manifest in a broad variety of ways. Chitapur, district Kalaburagi, was the site of the current research. Approximately 714 individuals participated in our research.

Identification of respiratory disease, easy case treatment, good vaccination practice, breastfeeding of newborns and nutrition of children, and reduction of home air pollution should be the primary goals of community education initiatives.

Possible under-enumeration might occur if moms did not record all occurrences that happened between the monthly appointments. In order to determine the potential dangers, we administered a questionnaire. Therefore, it's possible that the exposure was misclassified.

The discrepancy in the reported incidence of ARI between our study and others may be because to variations in the definition of ARI. At least one symptom was required for each episode of ARI to be classified in our research.

The mother has to know that chilly weather really helps bring on ARI rather than just making it worse, and that the negative connotation of bananas is completely unfounded. They need to know about health promotion strategies like helping the kid blow their nose, keeping them warm when it's chilly outside, and making the environment more humid to ease their upper respiratory tract if they're sick.

The test group's KAP scores were higher than the control group's after the intervention. In this way, the chemist plays a crucial role in ARI prevention and control efforts involving children.

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