

A DESCRIPTIVE STUDY TO ASSESS THE PERCEIVED PREPAREDNESS OF CHILDREN REGARDING ADOLESCENT HEALTH IN A SELECTED URBAN AREA.

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Abstract: **BACKGROUND OF STUDY :** The age group of 10–12 years (late childhood) is a critical threshold. Many health interventions target older adolescents (15–19), leaving younger children to navigate the onset of puberty with "accidental" or unreliable information from peers and social media. There is an urgent need to assess if these children are being reached before they enter this high-risk phase. In most countries, health systems and services are mainly designed for either young children or adults. Given their specific health and development needs, adolescents require responsive anticipatory models of service delivery. Due to biological and gender-based differences that result in varied health risks and disease incidence, these health services must always apply an appropriate 'gender lens.' Governments need to reach adolescents with high quality, well-coordinated and well integrated programs in their everyday context. These demands coordinated multi-sectoral action across a range of service delivery platforms, and should be complemented by laws guaranteeing that adolescents have access to services. Mechanisms for meaningful adolescent participation are missing in many settings. Achieving Universal Health Coverage for adolescents requires that adolescents themselves are empowered to initiate action and influence decisions that affect their health and development through meaningful participation. Adolescents are often not organized for advocacy, and decision making is rarely informed by adolescent rights. **AIM;** To assess the perceived preparedness of children regarding adolescent health. **MATERIALS AND METHODS:** In this study, Quantitative approach and descriptive design is adopted to assess the perceived preparedness of children regarding adolescent health. The study is conducted in schools and households located in urban areas of Maharashtra state. 100 samples who satisfied the inclusion criteria were recruited using non-probability convenient sampling technique from study population. A validated structured questionnaire was used to assess the perceived preparedness of the children. Data were analysed using descriptive statistics and inferential statistics. **RESULT:** A total of 100 children participated in the study to assess perceived preparedness regarding adolescent health. The mean perceived preparedness score of the children was 79.45 ± 10.16 , with scores ranging from 60 to 99, indicating an overall good level of preparedness regarding adolescent health. Classification of preparedness levels revealed that 57% of the children were highly prepared, whereas 43% were moderately prepared. No participant was categorized as mildly prepared, suggesting a generally favourable level of preparedness among the study population .

Keywords: Assess, perceived preparedness, adolescent

INTRODUCTION

Adolescence, defined by the World Health Organization (WHO) as the period between 10 and 19 years, is a unique and rapid phase of human development. It represents a critical transition from childhood to adulthood, characterized by profound physical, cognitive, and psychosocial growth. Globally, there are approximately 1.3 billion adolescents, accounting for one-sixth of the world's population. India alone holds the largest share of this demographic, with 253 million individuals (roughly every fifth person in the country) in this age group.

A Period of Vulnerability and Opportunity

While often perceived as a healthy stage of life, adolescence is a window of extreme vulnerability. It is during these years that individuals establish lifelong patterns of behavior related to diet, physical activity, and substance use. Nearly 70% of premature adult deaths are associated with behaviors initiated during adolescence, such as smoking or alcohol consumption. Conversely, investing in this stage yields a "triple dividend":

- Immediate health benefits for the adolescent.
- Improved health in their future adult life.
- Better health outcomes for the next generation.

Healthy adolescents also fuel economic growth by contributing to increased productivity, reduced health expenditure, and the interruption of intergenerational transmission of poor health, poverty and discrimination.

For every dollar invested in adolescent health, there is an estimated ten-fold health, social and economic return.

Research Approach

Quantitative approach was adopted to assess perceived preparedness of children regarding adolescent health.

Research Design

Descriptive research design was applied

Sampling technique

Non-probability convenient sampling technique.

Setting of the Study

The study was conducted in selected urban schools and households of Maharashtra.

Sample Size

The sample size included for the study consist of 100 children who met the inclusion criteria.

Description of Tool

Section-A: Deals with 3 items seeks information regarding socio demographic variables of children

Section-B: It contains 33 structured questionnaire items under 8 headings which seeks information based on perceived preparedness of children in various aspects of adolescent health like biological knowledge, self care and hygiene self efficacy, emotional and social resilience, communication support, digital literacy and safety, social boundaries and consent, identity and self image, nutrition and dietary practices.

Section I:

Description of Demographic Variables

Table 1: Distribution of Children According to demographic variables (N = 100)

Sl.No	DEMOGRAPHIC CHACHARACTERSTICS	Frequency (f)	Percentage (%)
1.1	Age		
	9 to 10 years	13	13.0
	10 to 11 years	22	22.0
	11 to 12 years	65	65.0
1.2	Gender		
	Boy	48	48.0
	Girl	52	52.0
1.3	Source of Information		
	Parents	31	31.0
	Online resources and Books	56	56.0
	Teachers	13	13.0

Table 1 depicts the demographic characteristics of the children. **Age:** The majority of children 65 (65%) belonged to Age 11 to 12 years, followed by 22(22%) in Age Group 10 to 11 years and 13(13%) in Age Group 9 to 10 years. **Gender:** More than half of the children 52 (52%) were girls, while 48 (48%) were boys. **Source of information:** Most children 56 (56%) reported online resources and books as their source of information, followed by parents 31 (31%) and teachers 13 (13%).

Data collection process

To conduct research study formal permission was obtained from the college authority and the ethical committee. After accepting the permission, the following steps were taken up:

Step 1-Researcher introduced themselves and explains the purpose of the research study to the subjects and an informed assent was taken.

Step 2 - Administration of structured questionnaire to assess the perceived preparedness of children regarding adolescent health.

Step 3 - Collection of data.

Step 4 - Analysis of collected data.

DATA ANALYSIS AND INTERPRETATION

This section outlines the methods and statistical techniques used in the study to analyse the collected data, followed by a detailed interpretation of the findings in relation to the research objectives.

SECTION: I

This section deals with Analysis of demographic characteristics of the children under study. It is analysed and presented in the form of frequency and percentage table.

SECTION: II

In this section Analysis and interpretation of data is done in order to find out association of perceived preparedness score with selected demographic variables of the childre

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Table 2: Descriptive Statistics of Perceived Preparedness Score (N = 100)

Variable	Mean	Median	SD	Minimum	Maximum
Perceived Preparedness Score	79.45	79.50	10.16	60	99

The mean perceived preparedness score was 79.45 ± 10.16 , indicating a generally good level of preparedness among children regarding adolescent health.

Table 3: Distribution of Children According to Preparedness Level (N = 100)

Preparedness Level	Score Range	Frequency (f)	Percentage (%)
Mildly Prepared	33–55	0	0.0
Moderately Prepared	56–77	43	43.0
Highly Prepared	78–99	57	57.0

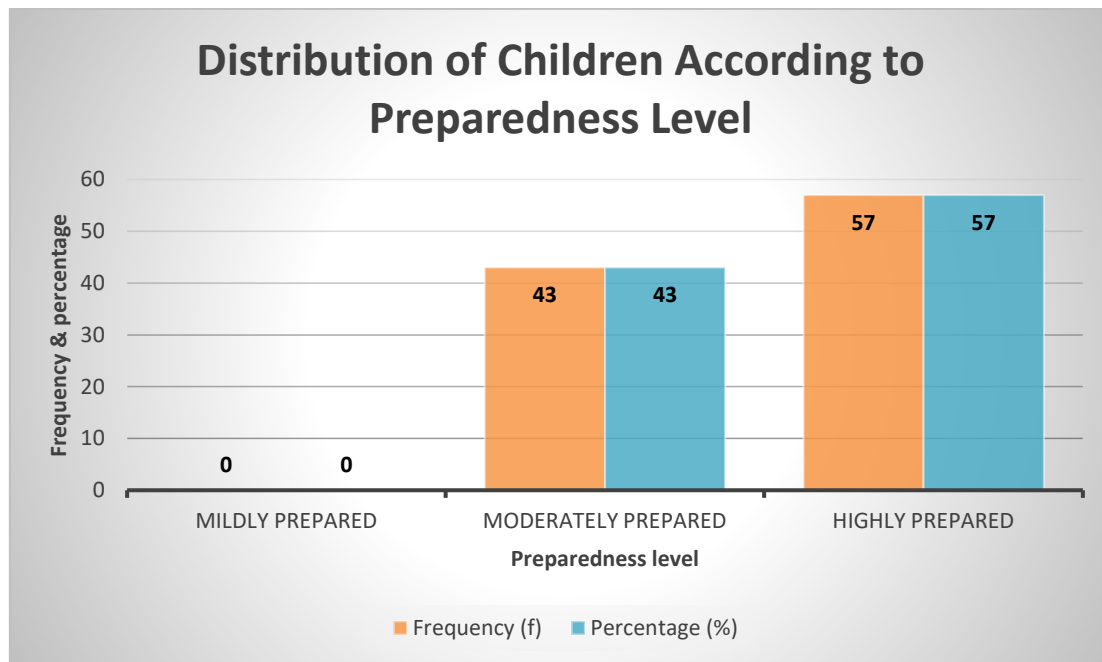


Figure 1: Distribution of Children According to Preparedness Level (N = 100)

Table 3 and figure 1 explains the overall perceived preparedness of children regarding adolescent health. It was found to be satisfactory. More than half 57 (57%) of the children were highly prepared, whereas 43 (43%) were moderately prepared. No child was categorized as mildly prepared, suggesting an overall favourable level of preparedness among the study participants.

Table 4: Age-wise Distribution of Preparedness Score (N = 100)

Age Group	Moderately Prepared f (%)	Highly Prepared f (%)	Total
9 to 10 years (n = 13)	7 (53.8%)	6 (46.2%)	13
10 to 11 years (n = 22)	10 (45.5%)	12 (54.5%)	22
11 to 12 years (n = 65)	26 (40.0%)	39 (60.0%)	65
Total	43 (43.0%)	57 (57.0%)	100

Among Age Group 9 to 10 years, 7 (53.8%) were moderately prepared and 6 (46.2%) were highly prepared where as among Age Group 10 to 11 years, 10 (45.5%) were moderately prepared and 12 (54.5%) were highly prepared. Among Age Group 11 to 12 years, 39 (60.0%) were highly prepared and 26 (40.0%) were moderately prepared. Overall, 57 (57%) of children were highly prepared, while 43 (43%) were moderately prepared. The proportion of highly prepared children increased across the age groups, with the highest percentage observed in Age Group 11 to 12 years.

Section II:

Table 5: Association Between Perceived Preparedness Score and Demographic Variables

Demographic variables	Group	Mean $\pm$ SD	F-value	p-value	Whether significant at 0.05 levels
Age	9 to 10 years	78.31 $\pm$ 9.97	0.424	0.656	Not Significant
	10 to 11 years	78.09 $\pm$ 8.03			
	11 to 12 years	80.14 $\pm$ 10.88			
Gender	Boy	78.96 $\pm$ 11.14	0.46	0.647	Not Significant
	Girl	79.90 $\pm$ 9.24			
Source of information	Parents	76.97 $\pm$ 10.86	4.42	0.014	Significant
	Online resources and books	79.16 $\pm$ 9.38			
	Teachers	86.62 $\pm$ 9.00			

Table 5 displays the analysis of association between demographic variables and perceived preparedness scores at significant association at the 0.05 level.

Association analysis demonstrated that age was not significantly associated with perceived preparedness scores ($F = 0.424$, $p = 0.656$). Similarly, no statistically significant difference was observed between boys and girls in preparedness scores ($t = 0.46$, $p = 0.647$). However, a significant association was found between source of information and perceived preparedness score ($F = 4.42$, $p = 0.014$). Children who received information from teachers exhibited the highest preparedness scores (86.62 ± 9.00), followed by those obtaining information from online resources and books (79.16 ± 9.38) and parents (76.97 ± 10.86).

DISCUSSION

A total of 100 children participated in the study. The perceived preparedness of the children regarding adolescent health was assessed using a structured questionnaire. The majority of the participants (65%) were aged 11–12 years, while 22% belonged to the 10–11 years age group and 13% were aged 9–10 years. Gender distribution was nearly equal, with 52% girls and 48% boys. Regarding sources of information related to adolescent health, more than half of the children (56%) reported obtaining information from online resources and books, followed by parents (31%) and teachers (13%).

The mean perceived preparedness score of the children was 79.45 ± 10.16 , with scores ranging from 60 to 99, indicating an overall good level of preparedness regarding adolescent health. Classification of preparedness levels revealed that 57% of the children were highly prepared, whereas 43% were moderately prepared. No participant was categorized as mildly prepared, suggesting a generally favourable level of preparedness among the study population.

Age-wise analysis showed a gradual increase in the proportion of highly prepared children with increasing age. Among children aged 9–10 years, 46.2% were highly prepared; among those aged 10–11 years, 54.5% were highly prepared; and among children aged 11–12 years, 60.0% were highly prepared. Overall, 57% of the participants were highly prepared and 43% were moderately prepared.

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CONCLUSION

The findings indicate that children in the study possessed a satisfactory level of preparedness regarding adolescent health, with more than half demonstrating a high level of preparedness. Although preparedness tended to increase with age, neither age nor gender showed a statistically significant association with preparedness scores. In contrast, the source of information significantly influenced preparedness levels, with children receiving information from teachers exhibiting significantly higher preparedness scores than those relying on parents or online resources. These findings underscore the importance of school-based health education and the role of teachers in preparing children for healthy adolescence.

SOURCE OF FUNDING

None

CONFLICT OF INTEREST

None.

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