A Comparative Analysis on Health Status of Residential Students of Madrasa in Bangladesh

A Dissertation submitted to the Department of Pharmacy, East West University, Bangladesh, in partial fulfillment of the requirements for the Degree of Bachelor of Pharmacy

Submitted by

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Declaration by the Research Candidate

I, Kazi Tanvir Islam, ID: 2012-1-70-041, hereby declare that the dissertation entitled "A comparative analysis on health status of residential students of madrasa in Bangladesh" submitted by me to the Department of Pharmacy, East West University in partial fulfillment of the requirement for the award of the degree of Bachelor of Pharmacy is a record of research work under the supervision and guidance of Nigar Sultana Tithi, Senior Lecturer, Department of Pharmacy, East West University, Dhaka.

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Certificate by the Supervisor

This is to certify that the thesis entitled " A comparative analysis on health status of residential students of madrasa in Bangladesh " submitted to the Department of Pharmacy, East West University for the partial fulfillment of the requirement for the award of the degree of Bachelor of Pharmacy is a record of original and genuine research work carried out by Kazi Tanvir Islam, ID: 2012-1-70-041 during the period 2015, under my the supervision and guidance.

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This is to certify that the thesis entitled "A comparative analysis on health status of residential students of madrasa in Bangladesh" submitted to the Department of Pharmacy, East West University for the partial fulfillment of the requirement for the award of the degree of Bachelor of Pharmacy is a record of original and genuine research work carried out by Kazi Tanvir Islam, ID: 2012-1-70-041 during the period 2015.

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Abstract

In Bangladesh 2.4 million students are studying in madrasa. Life style of residential madrasa students has an impact on their health and disease pattern. The main objective of this study was to find out the living parameters related to their development of health and disease pattern, their knowledge about sanitation and other health regards. They did not get nutritional diet (more than 70% do not get enough protein). High meal skipping tendency was found from the study. As a good number of students were unconscious of hygiene and sanitation practice and had a habit of junk food intake (highest in Dhaka 83%) most of them suffered from various kinds of diseases like GI disorder, fever, common cold, skin infection on a regular basis (77%). Majority of the students knew about their health service right (76%). They were deprived of regular physical exercise and sports due to not having playground facilities in most of the institution (highest facilities in Chittagong 71.50%). Accommodation facilities provided by the institution were not very satisfactory. Moreover most of the students faced sanitation problem due to less number of toilet and lack of clean toilet. Most of the institutions did not have healthcare professional (worst scenario was found in Rajshahi). Students were deprived of entertainment which may inhibit their mental development. But it was found that most of the students were happy to stay in the institution (more than 90%). Overall findings suggest that both the students and the madrasa authority were not conscious about the health of the students. Steps should be taken to provide the students better health guide and improved facilities to live a healthy life.

Key words: *Madrasa students, lifestyle, health, disease, facilities, sanitation, mental development.*

Chapter 1

Introduction

Introduction

1.1 Madrasa

Madrasa is the Arabic word for any type of educational institution, whether secular or religious (of any religion). Variously, transliterations appear: *Madrasa*, *madarasaa*, *medresa*, *madrassa*, *madraza*, *medrese*, etc. In the West, the word usually refers to a specific type of religious school or college for the study of the Islamic religion, though this may not be the only subject studied. Not all students in madrasas are Muslims; there is also a modern curriculum (Rahman, 2013).

Madrasa education is a system whereby Islamic branches of knowledge are taught besides the teaching of general branches of knowledge. Madrasas are generally known as "religious schools". According to Dr. Manaros B. Boransing, "Madrasa generally refers to Muslim private schools with core emphasis on Islamic studies and Arabic literacy." Madrasas are usually privately-operated schools, which rely on the support of the local community or foreign donors and Governments, particularly from Islamic or Muslim countries (Amin, 2013).

1.2 Madrasa in Bangladesh

1.2.1 Types of Madrasa

There are two types of Madrasas in Bangladesh. One is known as Alia Madrasa and the other is known as Qawmi Madrasa. The first Alia Madrasa was established in this sub-continent in 1780 by the British Government. Eventually, the Madrasa Education Board of Bengal was established that formed the foundation for formal Madrasa education in this part of the sub-continent (Amin, 2013).

Prior to the independence of Bangladesh in 1971, Alia Madrasas in East Pakistan used to focus only on Arabic Literature and subjects related to Islamic knowledge. After the independence of Bangladesh, some steps were taken to modernize Madrasa education system. General subjects like Bengali, Mathematics, English, Social Science, and General Science were made compulsory. In 1978, the Madrasa Education Board was formed under the Ordinance for the Modernization of Madrasa Education.

Qawmi Madrasas, on the other hand, are not guided by the Government. This parallel system is entirely controlled and operated by the private sector that actually relies on the support of the local community or foreign donors. In the Qawmi Madrasa system, students are taught only Arabic and subjects pertaining to Islamic knowledge (Anim, 2013).

1.2.2 Students of Madrasa

According to the report of Bangladesh Bureau of Educational Information and Statistics (BANBEIS) A total of 1.4 million students have been studying in 13,902 Qawmi madrasas across the country. According to The Controller of Bangladesh Madrasa Education Board about 1 million students studying in 20,446 Alia Madrasa. Most of the students are residential. They come from different region of the country (Prothom-alo, 2015).

1.3 Guideline of General Health Practice

1.3.1 Food and Nutrition

Good nutrition is essential for everyone, but it’s especially important for growing teenagers. Unfortunately, many Australian teenagers have an unbalanced diet. From the 2007 Australian National Children's Nutrition and Physical Activity survey, teenage boys and girls aged 14 to 16 ate only half the recommended serves of fruits and vegetables per day. One in three adolescents buys unhealthy takeaway food every day. If teenagers eat takeaway food regularly, they are more likely to put on weight than if they eat fast food only occasionally. It may require some effort to change their eating habits, but even a few simple changes will make a huge difference. They will feel better and may find managing their weight easier (better health, 2014).

Nutrition for adolescents (teenagers) means giving them enough nutrients from age 12 to18 years of age. Teenagers will go through several growth spurts during this time. They will become taller and gain weight quickly. Make sure they have a wide variety of food for snacks and meals. These will give them enough nutrients in the food they eat. Nutrients are calories, protein, fat, vitamins, and minerals (Drugs.com, 2015).

1.3.1.1Nutrient Needs:

The amount of calories and protein that teenagers need each day depends on their age and weight in kilograms. Divide teenager's weight in pounds by 2.2 to figure out what he weighs in kilograms (kg). The calories and protein needed for growth are higher if the teenager is active in sports or fitness programs. According to the height and weight of the teenager a regular diet must be maintained which can be provided by caregivers. They can help to raise or lower calorie intake to stay at the best weight.

Calories

- From age 13 to 15: about 2300 to 2800 calories per day
- Age 16 to 20: about 2800 to 3200 calories per day

Protein

- Age 13 to 15: about 52 gram per day
- Age 16 to 20: about 65 grams per day (Drugs.com, 2015).

1.3.1.2 Vitamins and minerals: Teenager does not need to take extra vitamins or minerals if he eats a balanced diet. It must be asked from caregiver before giving any vitamin or mineral supplements to the teenagers (Drugs.com, 2015).

1.3.1.3 Changing Food Habits

- Teenagers are often very busy with school, work, and sports schedules. They must avoid having Junk Food. They may need extra snacks to take with them or meals they can prepare quickly.

- Teenagers still learn from parents healthy eating habits. They must be taught by example and praise their good food choices. Parents should not be critical of their appearance at this time of life. Teenagers can easily become too worried about their body image. If they are eating too much or too little, it can affect their growth (Drugs.com, 2015).

1.3.1.4 Food Group Choices

- Give teenager at least one serving per day of a high vitamin C food. Examples are citrus fruits and juices, tomatoes, potatoes, and green peppers. Teenager

also needs one serving per day of a high vitamin A food. This includes spinach, winter squash, carrots, or sweet potatoes.

- Choose lean meats, fish, and poultry foods for teenager. Also, give teenager 2% milk and low fat dairy foods after age 2 to limit saturated fat intake. Avoid fried foods and high fat desserts except on special occasions. This will lower his risk for heart disease when he is older (Drugs.com, 2015).

1.3.1.5 DAILY SERVINGS FOR AN TEENAGER'S DIET

- **Breads / Starches:** Most teens need 5 to 10 servings per day. One serving is the amount listed below.

1 bagel or muffin, 2 slices bread, 1/2 cup cooked cereal, pasta, potatoes, or rice, 1 ounce or 3/4 cup dry cereal

- **Fruits:** Most teens need 2 to 3 servings per day. One serving is the amount listed below.

1/2 cup canned fruit or fruit juice, 1 piece fresh fruit, such as an apple, orange, peach, or pear

- **Meat / Meat Substitutes:** Most teens need 3 to 5 servings per day. One serving is the amount listed below.

1/2 cup cottage or ricotta cheese, 3/4 to 1 cup cooked dried beans or legumes, 1 egg, 1 ounce low fat or regular cheese, 2 to 3 ounces meat, fish, or poultry, 2 to 3 table spoons peanut butter (after age 2)

- **Milk or Yogurt:** Most teens need 4 to 5 servings per day. One serving is equal to 1 cup low fat milk or yogurt. If your teenager does not like milk or yogurt, one ounce of cheese or 1/2 cup of cottage cheese may be used instead.

- **Vegetables:** Most teens need 2 to 3 servings per day. One serving is the amount listed below.

1/2 cup cooked or 1 cup raw vegetable, 2 cups salad greens, 1 cup vegetable or tomato juice

- **Fats:** Most teens need 2 to 4 servings per day. One serving is the amount listed below.

6 almonds or 10 peanuts, 2 table spoons. cream cheese, avocado, or low calorie salad dressing, 1 teaspoon oil.

- **Sweets and Desserts:** Eat only enough from this group to stay at a good body weight. Many teenagers can eat 1 to 3 servings per week without gaining too much weight. Remember too much sweet and desserts will also affect the amount of skin problems your teenager has, like pimples. One serving is a medium portion, such as 1/8 of a pie, 1/2 cup ice cream, a 3-inch pastry,1/2 cup pudding, or 2 small cookies (Drugs.com, 2015).

1.3.2 Personal Hygiene for Teenagers

Everyday personal hygiene is basically about washing hands, covering mouth when coughing and keeping clean. But there's also a social side to dealing with personal things like body odor, smelly feet and bad breath.

Keeping clean is an important part of staying healthy. For example, the simple act of washing hands before eating and after using the toilet is a proven and effective tool for fighting off germs and avoiding sickness. Being clean and well-presented is also an important part of confidence for teenagers. If teenagers' body and breath smell normal, their clothes are clean, and they are on top of his basic personal hygiene, it can help them fit in with other people (raisingchildren, 2015).

If teen is resistant to basic teen hygiene -- like showering after practice or using deodorant -- don't just nag or plead. Explain that taking care of him is a responsibility, and start treating it like his other household duties. Just as he is supposed to take out the trash and keep his room clean, he now has to look after his hygiene. If he doesn't, there should be clear repercussions, like revoked privileges (WebMD, 2010; raisingchildren, 2014).

1.3.2.1 Hand washing

The Centers for Disease Control and Prevention (CDC) recommends regular hand washing all day long, before and after certain activities. This small step is one of the

best preventative measures a child can take to avoid sickness and halt the spread of germs to other children.

The CDC states that washing hands with soap and water is the best way to reduce the number of microbes on hands in most situations. 60% alcohol-based hand sanitizer should only be used to clean hands when soap and water are not available.

The CDC provides simplified hand washing guidelines for kids and adults alike. Remember to wash:

- Before eating.
- Before and after interacting with someone who is sick.
- Before and after treating a cut.
- After using the restroom.
- After coughing, sneezing, or blowing the nose.
- After interacting with an animal or animal waste.
- After throwing away or touching garbage (Portapotty.net, n.d.).

1.3.2.2 Showering

Most elementary school kids don't shower every day. Once puberty hits, daily showering becomes essential. Recommend that they use a mild soap and concentrate on the face, hands, feet, underarms, groin and bottom. Washing under the fingernails is key, too. Discuss the pros and cons of daily hair washing. Some teens may prefer to skip days to prevent their hair from drying out. Others may want to wash their hair daily -- especially if they have oily hair, which can both look greasy and aggravate acne (WebMD, 2010; raisingchildren, 2014).

1.3.2.3 Maintaining good oral health

Teens can get pretty lax about their oral hygiene. But brushing and flossing are crucial, especially if they're drinking coffee and sugary, acidic sodas and sports drinks. It's not only about tooth decay. Bad oral hygiene leads to bad breath -- and that's something that no teen wants (WebMD, 2010; raisingchildren, 2014).

1.3.2.4 Changing clothes

Before puberty, kid might have gotten away with wearing the same shirt -- or even the same underwear and same socks -- day after day without anyone noticing. After puberty, that won't fly. Get teen to understand that along with showering, wearing clean clothes each day is an important part of teen hygiene. Point out that cotton clothes may absorb sweat better than other materials (WebMD, 2010; raisingchildren., 2014).

1.3.2.5 Using deodorant or antiperspirant

When children reach puberty, a sweat gland in their armpit and genital area develops. Skin bacteria feed on the sweat this gland produces, which is why teenagers and adults sometimes smell 'sweaty'. Bacteria feed on sweat in other parts of the body too, which can lead to body odor. When teens begin to notice it, using deodorant or an antiperspirant should become part of their daily teen hygiene (WebMD, 2010; raisingchildren, 2014).

1.3.3 Sleep

Sleep is food for the brain. During sleep, important body functions and brain activity occur. Skipping sleep can be harmful — even deadly. One can look bad, may feel moody, and perform poorly. Sleepiness can make it hard to get along with one's family and friends and hurt one's scores on school exams, on the court or on the field. A brain that is hungry for sleep will get it, even when one doesn't expect it. When any person do not get enough sleep, he/she is more likely to have an accident, injury and/or illness (National sleep foundation, 2015).

Sleep is vital to anyone's well-being, as important as the air one breathe, the water one drink and the food one eat. It can even help to eat better and manage the stress of being a teen. Biological sleep patterns shift toward later times for both sleeping and waking during adolescence -- meaning it is natural to not be able to fall asleep before 11:00 pm. Teens need about 8 to 10 hours of sleep each night to function best. Most teens do not get enough sleep — one study found that only 15% reported sleeping 8 1/2 hours on school nights. Teens tend to have irregular sleep patterns across the week — they typically stay up late and sleep in late on the weekends, which can affect their

biological clocks and hurt the quality of their sleep. Many teens suffer from treatable sleep disorders, such as narcolepsy, insomnia, restless legs syndrome or sleep apnea.

Children aged 13 to 18 need 8-10 hours of sleep. At the same time, there is an increasing demand on their time from school (e.g., homework), sports and other extracurricular and social activities. In addition, school-aged children become more interested in TV, computers, the media and Internet as well as caffeine products – all of which can lead to difficulty falling asleep, nightmares and disruptions to their sleep. In particular, watching TV close to bedtime has been associated with bedtime resistance, difficulty falling asleep, anxiety around sleep and sleeping fewer hours (National sleep foundation, 2015).

1.3.3.1 Sleep Tips for Teenagers

- Teach school-aged children about healthy sleep habits.
- Continue to emphasize need for regular and consistent sleep schedule and bedtime routine.
- Make child's bedroom conducive to sleep – dark, cool and quiet.
- Keep TV and computers out of the bedroom.
- Avoid caffeine (National sleep foundation, 2015).

1.3.4 Physical Activity

It's recommended that teens get at least 1 hour of physical activity on most, preferably all, days of the week. Yet physical activity tends to lag during the teen years. Many teens drop out of organized sports, and participation in daily physical education classes is a thing of the past.

But given the opportunity and interest, teens can get health benefits from almost any activity they enjoy skateboarding, in-line skating, yoga, swimming, dancing, or kicking a foot bag in the driveway. Weight training, under supervision of a qualified adult, can improve strength and help prevent sports injuries.

Teens can work physical activity into everyday routines, such as walking to school, doing chores, or finding an active part-time job. They can be camp counselors,

babysitters, or assistant coaches for young sports teams, jobs that come with a chance to be active

For children and young people, physical activity includes play, games, sports, transportation, chores, recreation, physical education, or planned exercise, in the context of family, school, and community activities (kidzHealth, 2015).

In order to improve cardiorespiratory and muscular fitness, bone health, and cardiovascular and metabolic health biomarkers:

- Children and youth aged 5–17 should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily.
- Amounts of physical activity greater than 60 minutes provide additional health benefits.
- Most of the daily physical activity should be aerobic. Vigorous-intensity activities should be incorporated, including those that strengthen muscle and bone, at least 3 times per week. For this age group, bone-loading activities can be performed as part of playing games, running, turning or jumping (WHO, 2015).

1.3.4.1 Importance of Physical activities

Being active is an important part of teenagers' daily routine. It's a great way to spend time with friends, meet new people, feel good and break up long stretches of sitting and studying.

Being active every day can help:

- improve heart health and fitness
- develop strong muscles, bones and good posture
- maintain a healthy weight
- improve concentration and memory
- learn new skills
- increase self-confidence

- reduce stress
- make and keep friendships
- improve sleep (raisingchildren, 2011).

1.3.4.2 Physical activity for all

These recommendations are relevant to all healthy children aged 5–19 years unless specific medical conditions indicate to the contrary.

The concept of accumulation refers to meeting the goal of 60 minutes per day by performing activities in multiple shorter bouts spread throughout the day (e.g. 2 bouts of 30 minutes), then adding together the time spent during each of these bouts.

Whenever possible, children and youth with disabilities should meet these recommendations. However they should work with their health care provider to understand the types and amounts of physical activity appropriate for them considering their disability.

These recommendations are applicable for all children and youth irrespective of gender, race, ethnicity, or income level.

For inactive children and youth, a progressive increase in activity to eventually achieve the target shown above is recommended. It is appropriate to start with smaller amounts of physical activity and gradually increase duration, frequency and intensity over time. It should also be noted that if children are currently doing no physical activity, doing amounts below the recommended levels will bring more benefits than doing none at all (WHO, 2015).

1.3.4.3 Benefits of Physical Activity for Young People

Appropriate practice of physical activity assists young people to:

- Develop healthy musculoskeletal tissues (i.e. bones, muscles and joints);
- Develop a healthy cardiovascular system (i.e. heart and lungs);
- Develop neuromuscular awareness (i.e. coordination and movement control);
- Maintain a healthy body weight.

Physical activity has also been associated with psychological benefits in young people by improving their control over symptoms of anxiety and depression. Similarly, participation in physical activity can assist in the social development of young people by providing opportunities for self-expression, building self-confidence, social interaction and integration. It has also been suggested that physically active young people more readily adopt other healthy behaviors (e.g. avoidance of tobacco, alcohol and drug use) and demonstrate higher academic performance at school (WHO, 2015).

1.4 Teen Mental Health

Mental health is a way of describing social and emotional wellbeing. Good mental health is central to teenagers' healthy development. It is associated with:

- feeling happy and positive about themselves and enjoying life
- healthy relationships with family and friends
- participation in physical activity and eating a healthy diet
- the ability to relax and to get a good night's sleep
- Community participation and belonging.

Teenagers need good mental health to build strong relationships, adapt to change and deal with life's challenges (raisingchildren, 2010).

Being a teenager is hard. They are under stress to be liked, do well in school, get along with thier family, and make big decisions. They can't avoid most of these pressures, and worrying about them is normal. But feeling very sad, hopeless or worthless could be warning signs of a mental health problem.

Mental health problems are real, painful, and sometimes severe. Teenagers might need help if they have the signs mentioned above, or if they

- Often feel very angry or very worried
- Feel grief for a long time after a loss or death
- Think their mind is controlled or out of control
- Use alcohol or drugs

- Exercise, diet and/or binge-eat obsessively
- Hurt other people or destroy property
- Do reckless things that could harm them or others

Mental health problems can be treated. To find help, they should talk with their parents, school counselor, or health care provider.

Here are some ideas to promote teen's mental health and wellbeing:

- Teen must be get love, affection and care from family and school.
- It should be shown that parents are interested teens' life. Parents should praise their good points and achievements, and value their ideas.
- Teenagers should enjoy spending time together one-on-one with parents, and also as a friends.
- Teens must be encouraged to talk about feelings with parents. It's important for teens to feel that they doesn't have to go through things on their own, and that they can work together to find solutions to problems.
- Problems must be dealt with as they arise, rather than letting them build up (raisingchildren, 2010.;medline plus, 2015).

1.5 Residential Students

Student living in hostels are a distinct group of university students who have unique needs and problems. They have particular physical, social and emotional characteristics. They are away from home and have to learn to manage their own affairs, and adjust to new conditions of living without a family member of greater experience to guide them. Also students who live independently are subject to less parental control that can inhibit unhealthy behavior. Such students are more prone to poor eating habits, lack of sleep, or the acquisition of new habits, such as smoking. All these factors do not contribute positively to the development of a healthy lifestyle. The hostels are residence halls where most students share facilities and common areas, such as bedroom, bathroom, kitchen, dining area, study room and television

room. The bedrooms can be single or double, or, to accommodate a large number of students may be dormitory style (WHO, 2007).

1.6 Problems of Madrasa students

As Madrasa students comes from different region of the country and for the for the first time out of their home they face a lot of problems to adjust the new environment. Most of them suffer to adjust with food habit, sleeping hours, sanitation facilities, entertainment, games. Sometimes students in the Madrasa face some mental problems also. Some major problems are discussed.

1.6.1 Food Habit

Balance diet is essential for all humans even deficiency of single nutrient cause fatal diseases. Madrasa Students are not enough mature to understand the importance of good diet so mostly they ignore proper food and diet. Essential nutrients like carbohydrates, essential amino acids, fat, vitamins and minerals are not only compulsory compounds for survival but these are very essential for their health. Even some students skip meals. Some students have bad habit of having outside junk foods which are hazardous to their health. These food may lead to many diseases. The source of drinking water is very important issue to follow. As polluted water may lead to many water borne diseases (Shah *et al*, 2013).

1.6.2 Sanitation Problems

World Health Organization defined sanitation as the means of collecting and disposing excreta and community liquids, waste in a hygienic way. So as not to endanger the health and welfare and also for the social and environmental effects, it may have on people; people have been suffering from one disease to another without knowing the problems of their illness, the situation and due to distress or dirty environment. Cleanliness is next to Godliness. In Madrasa, students face sanitation problem because of dirt toilet, less number of toilet, lack of toilet inside institution. These may cause hazard to their health (afribary, 2013).

1.6.3 Sleeping time

During sleep, important body functions and brain activity occur. Skipping sleep can be harmful even deadly, particularly if you are behind the wheel. One can look bad,

you may feel moody, and you perform poorly. When one do not get enough sleep, you are more likely to have an accident, injury and/or illness. Teens need about 8 to 10 hours of sleep each night to function best. Most teens do not get enough sleep — one study found that only 15% reported sleeping 8 1/2 hours on school nights. In Madrasa some students can not adjust their sleeping hours which may lead to some problem like limiting one's ability to learn, listen, concentrate and solve problems, make one more prone to pimples. Lack of sleep can contribute to acne and other skin problems lead to aggressive or inappropriate behavior such as yelling at friends (National sleep foundation, 2015).

1.6.4 Physical Activity

According to WHO a teenager should do at least one hour physical activities daily. This activities includes playing games, physical exercise etc. But in madrasa lack of playground, lack of time doesn't give the students to attend the physical activities. As a result their both physical and mental growth hampered (Marriot *et al*, 1997).

1.6.5 Accommodation

In Madrasa, students may face a lot of suffering through adjusting accommodation as sometimes they may have to share rooms, sharing beds. In some cases a lot number of students have to live in a single room which may lead to many problems like mental disturbance, spreading diseases etc. (Marriot *et al*, 1997).

1.6.6 Mental Development

Mental development of students is occurred during teen age. This period of life determines the mentality of future life of the students. So the students need special care for their proper development. They should be provided proper entertainment, they should get chance to express their thoughts with their parents and friends clearly. But in madrasa there is lack of proper care of their mental development. Sometimes they do not get the chance to express their emotion. Sometimes the seniors of the madrasa may behave rude to the junior which hampers their mental growth. Sharing beds, having fighting with fellow students in madrasa may affect badly their mental growth (Raising children, 2010).

Chapter 2

Literature Review

Literature Review

2.1 Health-related lifestyles and risk behaviors among students living in Alexandria University hostels

This assessment health related lifestyles and their determinants among 600 Alexandria students living in university hostels. Data were collected by questionnaires, and anthropometric University and blood pressure measurements were taken. Most students were not satisfied with their situation in terms of accommodation, health and support. About 86% ate unhealthy diets, 33.8% were physically inactive, 25.3% were overweight or at risk of becoming overweight, 17.5% of male students were smokers and 32.2% had poor sleep behaviors. About 28% of the students adopted 3 or more current risk behaviors. About 23% reported low perceived health status and 80.3% felt they had low to moderate social support. There were significant sex differences regarding some behaviors (Abolfotouh *et al*, 2007).

2.2 Secondary School Madrasas in Bangladesh: Incidence, Quality, and Implications for Reform

A unique feature of the Bangladeshi secondary education sector is the large presence of Islamic institutions of religious learning, commonly known as madrasas. However, unlike other countries in the region with large Muslim populations, the religious education sector comprises of both state regulated private madrasas as well as independent, private madrasas. The former are popularly known as Aliyah madrasas where alongside Islamic education, modern general education is also provided. Given that majority of these private registered madrasas operate with state funding, they are regulated in terms of curriculum content and teacher recruitment policy under a unified state recognized Madrasa Education Board. On the other hand, an unknown number of private, traditional madrasas exists outside the state sector. These seminaries specialize in religious education and are popularly known as "Quomi" madrasas (Asadullah *et al*, 2009).

2.3 Sanitation Practices and Implication On Students Health In Enugu State College Of Education

Sanitation practice implication on student's health in Enugu State College of Education (Technical) has been the desire of every right thinking for good health of both the students and lecturers in the above school. The purposes of this study is to investigate the causes of poor sanitation practices on students health in ESCET, the dangers and the strategies which could be employ to curb poor sanitation in ESCET. One hundred questionnaires were administered to the respondents, which was correctly answered by the respondents without mistakes five research question, each focusing on the formulated. A descriptive statistic using mean was adopted from data analysis. Finding from their study showed that, regular clean up exercise, formulating the environment, illiteracy constitutes the problems of poor sanitation practices. The study was concluded with the recommendation which includes that the school management should employ laborers, make provision for facilities, and formulate the environment. The researchers believed that if all these are put in place, it will enhance sanitation practices in the school, thereby improving students' health (Afribary,2013).

2.4 Nutritional Assessment of Hostel Residential and non Hostel Residential Boys and Girl Students of Sindh University, Jamshoro, Sindh, Pakistan

Nutrition has great importance for humans to survive whole life but it takes special attention during the study period. University Hostel students are totally dependents on their own care; they mostly ignore the importance of balance diet and nutrition which is necessary for the health and fitness of mind for a student to study to achieve the tasks assigned. Questionnaire was filled by all the students which contained economic condition, education, health, food pattern, height and weight of 100 of Boys and Girls Hostel Residential(HR) and Non Hostel Residential (NHR) students. Biochemical tests like blood Glucose, Albumin, Globulin, Total protein, A/G ratio and Hb was analyzed to evaluate the nutritional status of the students, for the statically analysis, Arithmetic mean, Standard Deviation, probability and Chi square distribution was calculated (Shah *et al,* 2013).

2.5 Students' Perception on the Service Quality of Malaysian Universities' Hostel Accommodation

This research aimed to evaluate students' perception on the service quality of Malaysian universities' hostel accommodation. Data was collected from the three Malaysian universities. The outcomes of this research were based on applicability of the Parasuraman et al (1988) service quality framework. For that purpose, 6 hypotheses were proposed to measure all framework related variables (e.g. reliability, responsiveness, assurance, empathy and tangibles). The results did support the applicability of the framework, as all hypotheses were proved to be supportive except one of them. Based on the precise outcomes, it can be said that on overall basis, students perceive service quality at universities 'residence halls to be slightly good. However, the analysis did indicate the fact that for the hostel management, a long distance is still to be covered to reach the level of excellence. If not do so, a slight more decreased in the overall perception level of students may gone negatively for the company (Bashir *et al*, 2012).

Objective of the study

The study was conducted with the following objective in view:

1. To survey the opinions of the students regarding various facilities available to them.
2. Identify health-related lifestyles among students, physical exercise and dietary habits.
3. Identify daily life problems in hostels and the students' satisfaction with their residence in hostels, accommodation facilities.
4. Identify different disease pattern, measures of treatment and sanitation practices among students in Madrasa.
5. Identify the mental health status of students of Madrasa.
6. To attempt comparison between inter Madrasa students.

Significance of study

From the study we will be able to know,

1. Whether the madrasa students are aware of hygiene or health practices like hand washing, good food habit, and physical exercise and also enable to have a sound health.
2. Whether the disease pattern of the madrasa students are related to their hygiene practice and food habit.
3. Whether the students are provided with playground facilities, accommodation facilities etc. by the madrasa authority

The findings will help the government, to formulate policies that will enable the authority of madrasa to provide their students good facilities and provide awareness programs

Chapter 3

Methodology

Methodology

3.1 Study Area

The study was conducted among 12 residential madrasa in three districts Dhaka, Chittagong and Rajshahi. Among the 12 madrasa 6 were Alia madrasa and other 6 were Qawmi madrasa.

3.2 Study Population

From June 2015 through November 2015 a total 600 residential madrasa students were observed for the analysis.

3.3 Inclusion Criteria

- Male students
- Having age between 13-20 years
- All the students lived in madrasa have been included.

3.4 Exclusion Criteria

- Female students
- Students living outside of madrasa have been excluded.

3.5 Procedure

For collecting data a questionnaire was prepared according to required information. Permission was taken from the authorized member of the madrasa before interview.

The collected data were analyzed with the help of Microsoft office Excel 2010. Some graphical representations were made from those analysis statuses.

Chapter 4

Results

Results

4.1 Age of the madrasa students

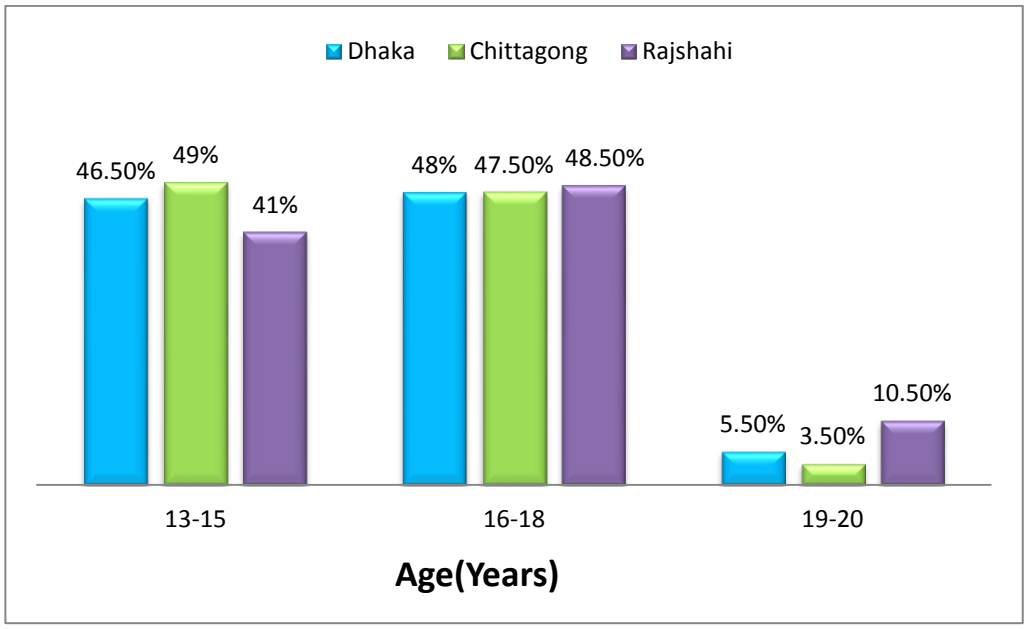


Figure 4.1: Age distribution of the madrasa students

In Dhaka among 200 students almost half of them were aged between 16-18 years (48%). A large percentage was aged between 13 to 15 years (46.50%). A few numbers from age range of 19 to 20 years old (5.50%).

In Chittagong among 200 students almost half of them were aged between 13 to 15 years (49%).A large percentage was aged between 16 to 18 years (47.50%). A few numbers of students from age range of 19-20 years old (3.50%).

In Rajshahi among 200 students almost half of them were aged between 16 to 18 years (48.50%).A large percentage was aged between 13 to 15 years (41%). A few numbers of students from age range of 19-20 years old (10.50%).

4.2 Duration of living in the institution

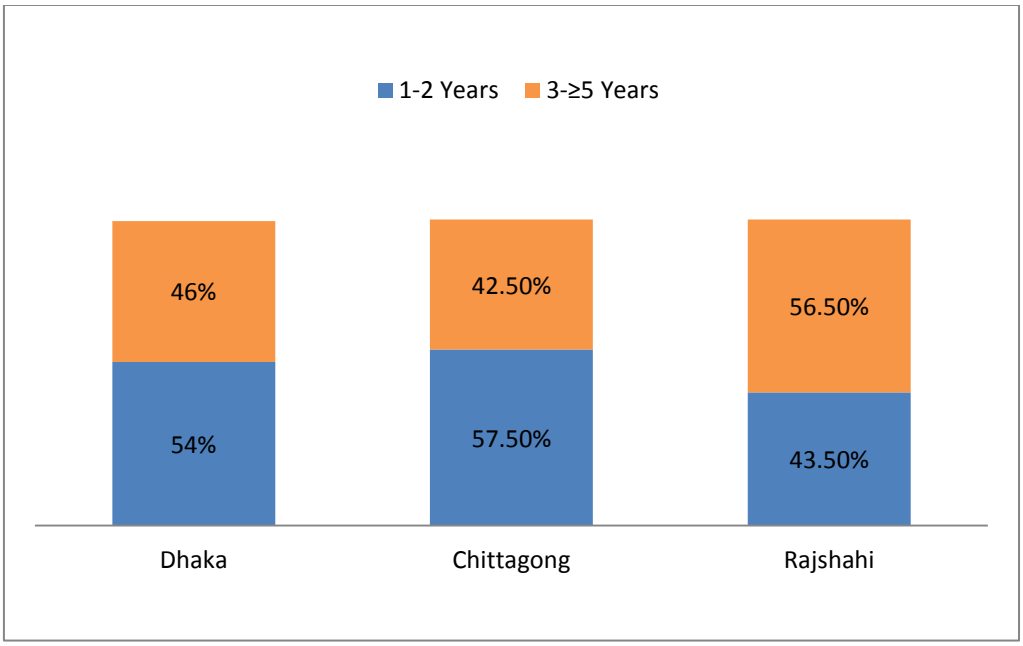


Figure 4.2: Duration of living in the institution

In Dhaka more than half of the respondents are living in the institution for 1 to 2 years(54%). Rest of the respondents are living for 3 to 5 or more than 5 years(46%).

In Chittagong more than half of the respondents are living in the institution for 1 to 2 years(57.50%). Rest of the respondents are living for 3 to 5 or more than 5 years(42.50%).

In Rajshahi more than half of the respondents are living in the institution for 3 to 5 or more than 5years(56.50%). Rest of the respondents are living for 1 to 2 years(43.50%).

4.3 Food Intake

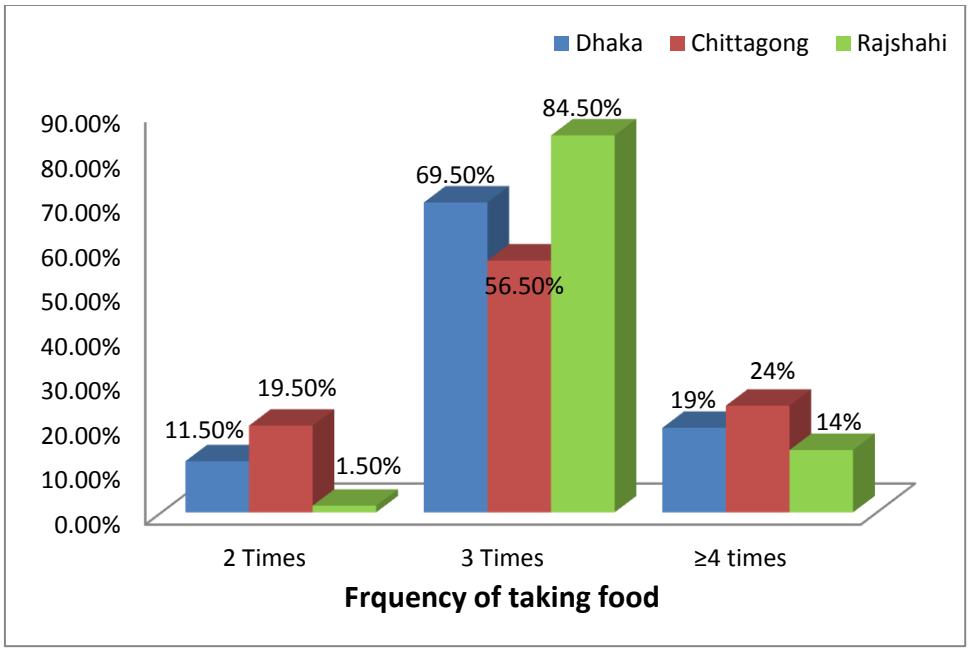


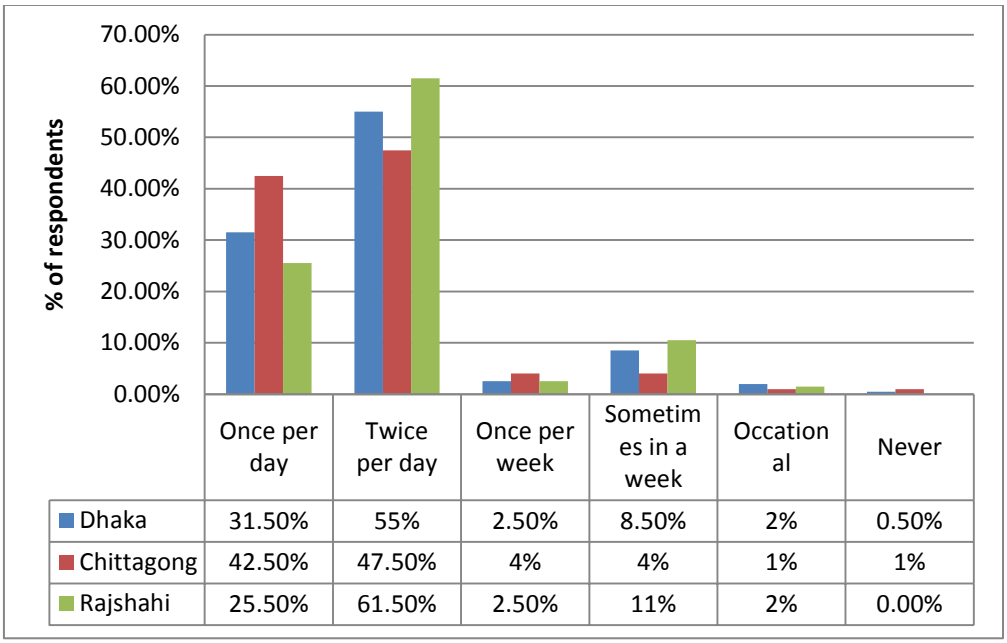
Figure 4.3: Frequency of taking food

In Dhaka among 200 students majority of the respondents take food 3 times per day (69.50%). 19% of the respondents take food 4 or more than 4 times. A few percentages of respondents take food 2 times in a day (11.50%).

In Chittagong among 200 students about half of the respondents take food 3 times per day (56.50%). 24% of the respondents take food 4 or more than 4 times. A few percentages of respondents take food 2 times in a day (19.50%).

In Rajshahi among 200 students majority of the respondents take food 3 times per day (84.50%). 14% of the respondents take food 4 or more than 4 times. A small percentage of respondents take food 2 times in a day (1.50%).

4.4 Vegetables Intake



	Once per day	Twice per day	Once per week	Sometimes in a week	Occational	Never
Dhaka	31.50%	55%	2.50%	8.50%	2%	0.50%
Chittagong	42.50%	47.50%	4%	4%	1%	1%
Rajshahi	25.50%	61.50%	2.50%	11%	2%	0.00%

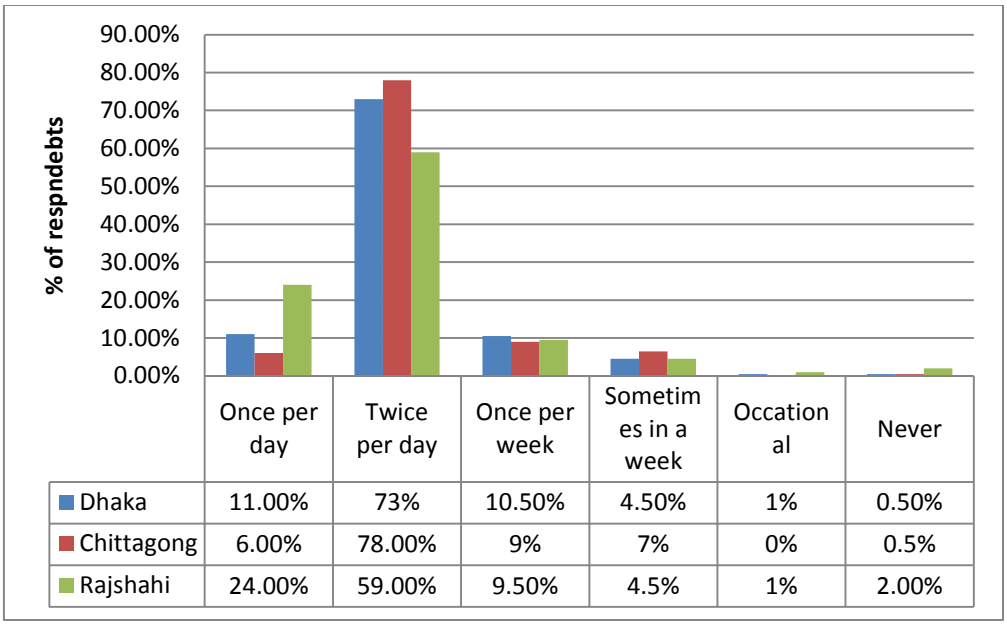
Figure 4.4: Vegetables intake frequency

In Dhaka more than half of the respondents eat vegetables twice per day (55%). 31.50% eat vegetables once per day. 2.50% eat once per week, 8.50% eat several times in a week, 2% eatoccasionally and 0.50% respondent never eat vegetables.

In Chittagong almost half of the respondents eat vegetables twice per day (47.50%). 42.50% eat vegetables once per day. 4% eat once per week, 4% eat several times in a week, 1% eat occasionally and 1% respondent never eat vegetables.

In Rajshahi more than half of the respondents eat vegetables twice per day (61.50%). 25.50% eat vegetables once per day. 2.50% eat once per week, 11% eat several times in a week, 2% eat occasionally. No respondent was found who does not eat vegetables.

4.5 Rice/Bread intake



	Once per day	Twice per day	Once per week	Sometimes in a week	Occational	Never
Dhaka	11.00%	73%	10.50%	4.50%	1%	0.50%
Chittagong	6.00%	78.00%	9%	7%	0%	0.5%
Rajshahi	24.00%	59.00%	9.50%	4.5%	1%	2.00%

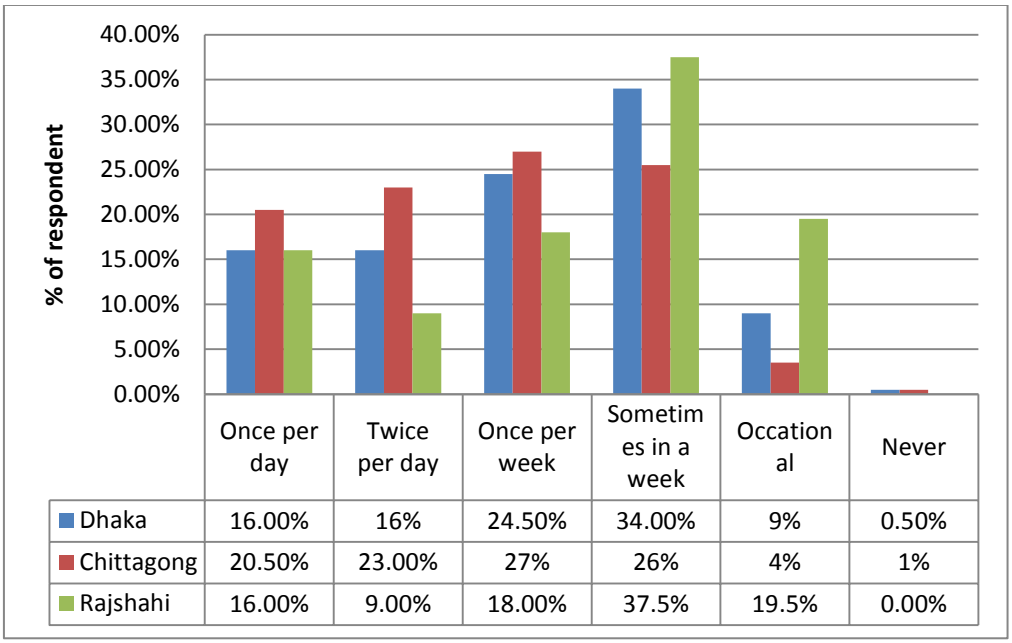
Figure 4.5: Rice/Bread intake frequency

In Dhaka a large number of the respondents eat rice/bread twice per day (73%). 11% eat rice/bread once per day. 10.50% eat once per week, 4.50% eat several times in a week, 1% eat occasionally and 0.50% respondent never eat rice/bread.

In Chittagong a large number of the respondents eat rice/bread twice per day (78%). 9% eat rice/bread once per week,6% eat once per day, 7% eat several times in a week and 0.50% respondent never eat rice/bread.

In Rajshahi more than half of the respondents eat rice/bread twice per day (59%). 24% eat rice/bread once per day. 9.50% eat once per week, 4.50% eat several times in a week, 1% eat occasionally and 2% never eat rice/bread.

4.6 Meat/Fish intake



	Once per day	Twice per day	Once per week	Sometimes in a week	Occational	Never
Dhaka	16.00%	16%	24.50%	34.00%	9%	0.50%
Chittagong	20.50%	23.00%	27%	26%	4%	1%
Rajshahi	16.00%	9.00%	18.00%	37.5%	19.5%	0.00%

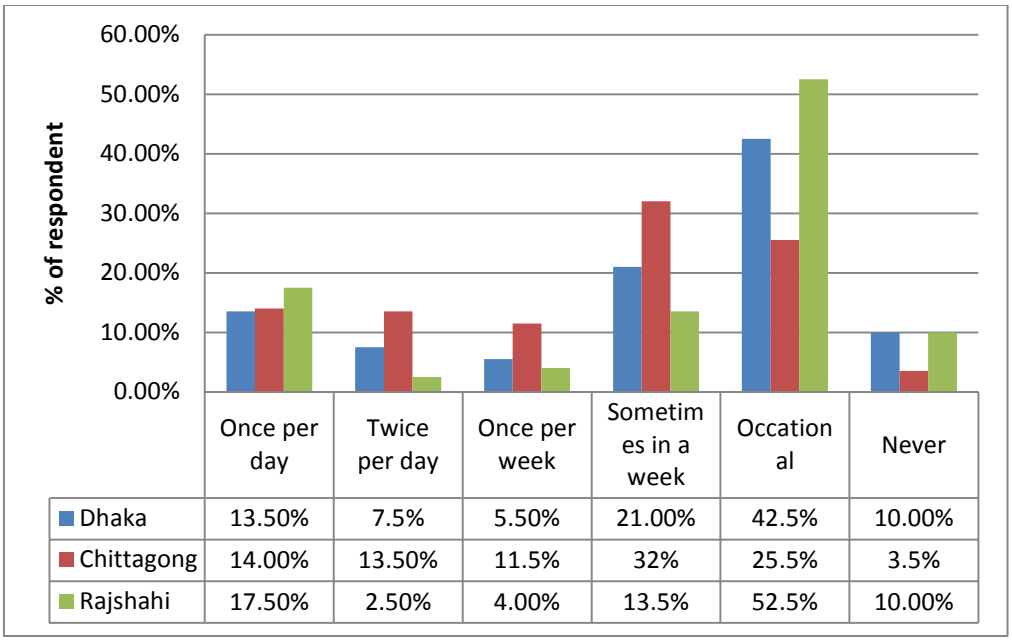
Figure 4.6: Meat/Fish intake frequency

In Dhaka among 200 respondents 34% eat meat/fish several times in a week, 16% eat once per day. 16% percent eat meat/fish once per day. 24.50% eat once per week, 9% eat occasionally and 0.50% respondent never eatmeat/fish.

In Chittagong among 200 respondents 27% eat meat/fish once in a week,26% eat several times in a week. 23% percent eat meat/fishtwice per day,4% eat occasionallyand 1% respondent never eatsmeat/fish.

In Rajshahi among 200 respondents37.50% eat meat/fish several times in a week, 19.50% eats occasionally. 18% eat meat/fish once per week, 16% eat once per day, 9% eat twice per day, No respondent was found who does not eat meat/fish.

4.7 Fruit intake



	Once per day	Twice per day	Once per week	Sometimes in a week	Occational	Never
Dhaka	13.50%	7.5%	5.50%	21.00%	42.5%	10.00%
Chittagong	14.00%	13.50%	11.5%	32%	25.5%	3.5%
Rajshahi	17.50%	2.50%	4.00%	13.5%	52.5%	10.00%

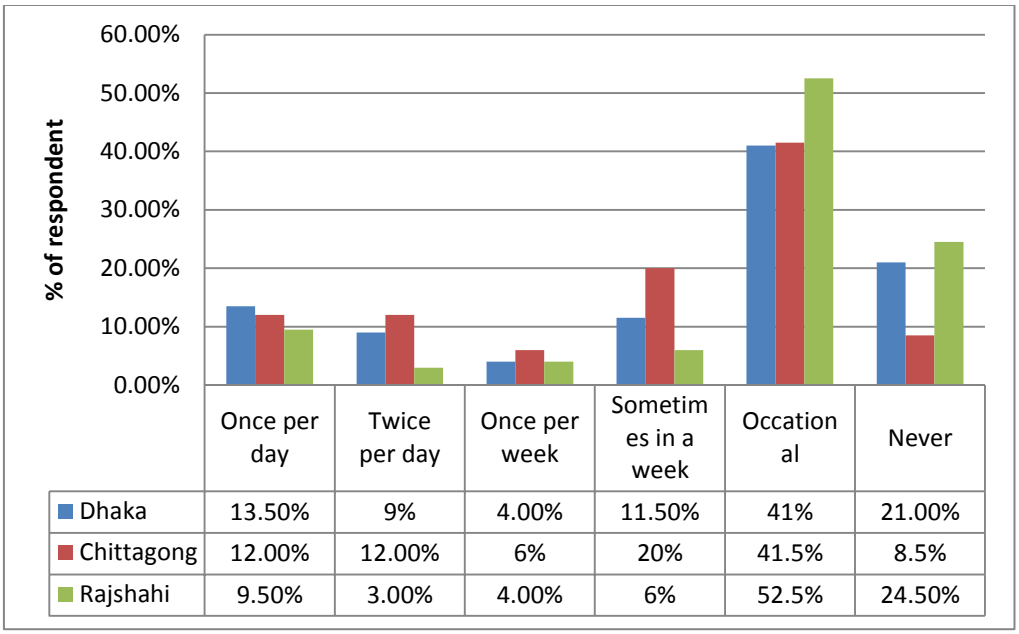
Figure 4.7: Fruit intake frequency

In Dhaka a large number of the respondents eat fruit occasionally (42.50%), 21% eat sometimes in a week. 13.50% eat fruit once per day, 10% respondent never eat fruit,7.50% eat twice per day and 5.50% eat once per week.

In Chittagong 32% respondents eat fruit several times in a week,25.50% eat occasionally.14% eat fruits once per day, 13.50% eat twice per day and 11.50% eats once per week and 3.5% respondents never eats fruit.

In Rajshahi more than half of the respondents eat fruit occasionally (52.50%), 17.50% eat once per day. 13.50% eat several times in a week.10% respondents never eat fruits, 4% eat once in a week, 2.50% eat twice per day.

4.8 Milk intake



	Once per day	Twice per day	Once per week	Sometimes in a week	Occational	Never
Dhaka	13.50%	9%	4.00%	11.50%	41%	21.00%
Chittagong	12.00%	12.00%	6%	20%	41.5%	8.5%
Rajshahi	9.50%	3.00%	4.00%	6%	52.5%	24.50%

Figure 4.8: Milk intake frequency

In Dhaka a large number of the respondents drink milk occasionally (41%). 21% respondents never drink milk. 13.50% drink milk once per day, 11.50% drink milk several times in a week, 9% drink twice per day and 4% drink once per week.

In Chittagong 41.50% respondents drink milk occasionally, 20% drinkseveral times in a week.12% drinkmilk once per day, 12% drink twice per day and 8.50% never drink milk and 6% respondents drink milk once per week.

In Rajshahi more than half of the respondents drink milk occasionally (52.50%), 24.50% never drink milk. 9.50% drink milkonce per day, 6% drink several times in a week,4% drink once per week and3% drink twice per day.

4.9 Skipping meal

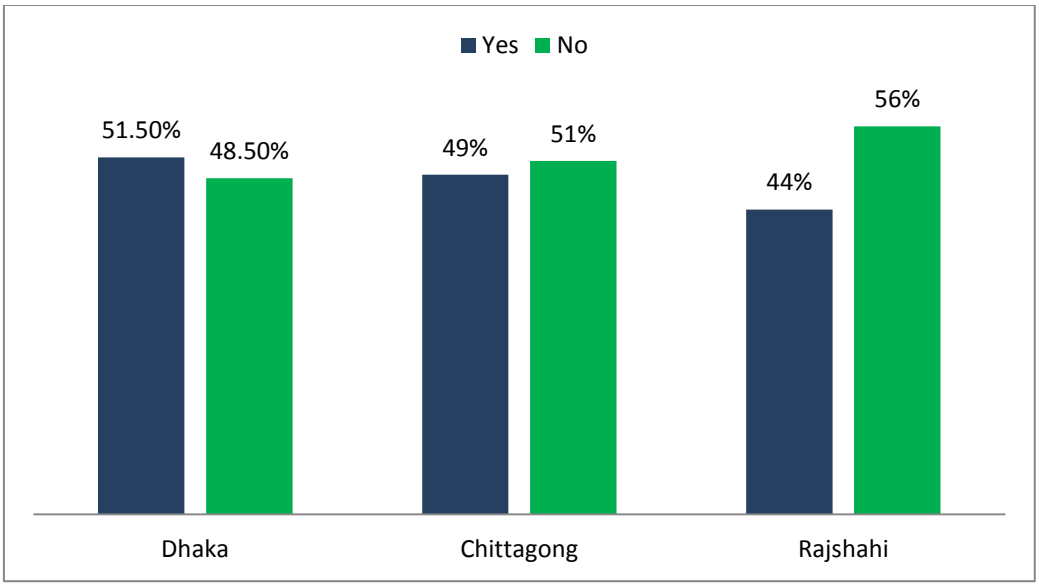


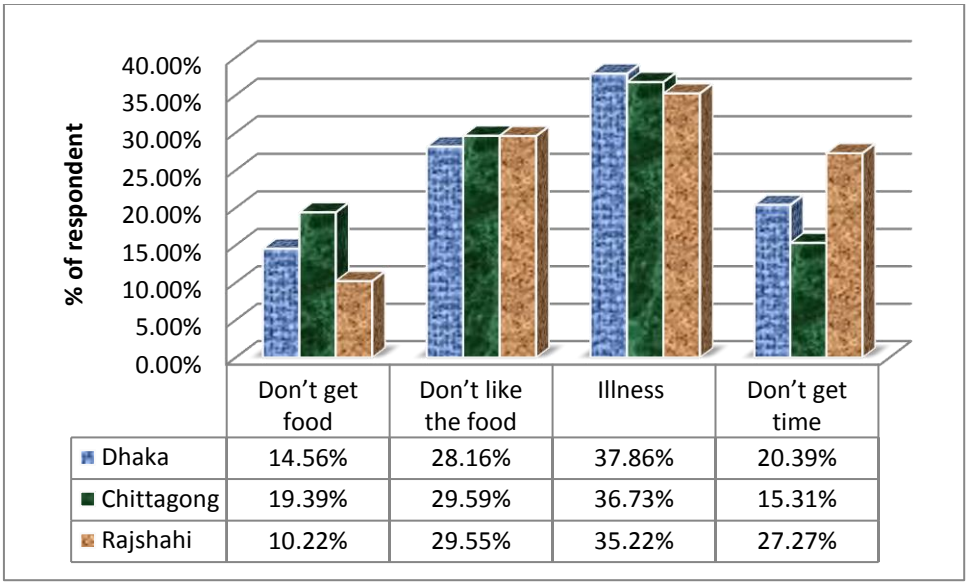
Figure 4.9: Meal skipping tendency

In Dhaka more than half of the respondents skip meal(51.50%). Rest of the respondents do not skip meal(48.50%).

In Chittagong more than half of the respondents do not skip meal(51%). Rest of the respondents skip meal(49%).

In Rajshahi more than half of the respondents do not skip meal(56%). Rest of the respondents skip meal(44%).

4.10 Reason behind skipping meal



	Don't get food	Don't like the food	Illness	Don't get time
Dhaka	14.56%	28.16%	37.86%	20.39%
Chittagong	19.39%	29.59%	36.73%	15.31%
Rajshahi	10.22%	29.55%	35.22%	27.27%

Figure 4.10: Reason behind skipping meal

In Dhaka among 103 respondents who skip meal 37.86% showed illness, 28.16% showed they don't like the food, 20.39% showed they don't get time, 14.56% showed they don't get food as their reason behind skipping meal.

In Chittagong among 98 respondents who skip meal 36.73% showed illness, 29.59% showed they don't like the food, 19.39% showed they don't get food, 15.31% showed they don't get time as their reason behind skipping meal.

In Rajshahi among 88 respondents who skip meal 35.22% showed illness, 29.55% showed they don't like the food, 27.27% showed they don't get time, 10.22% showed they don't get food as their reason behind skipping meal.

4.11 Junk food intake

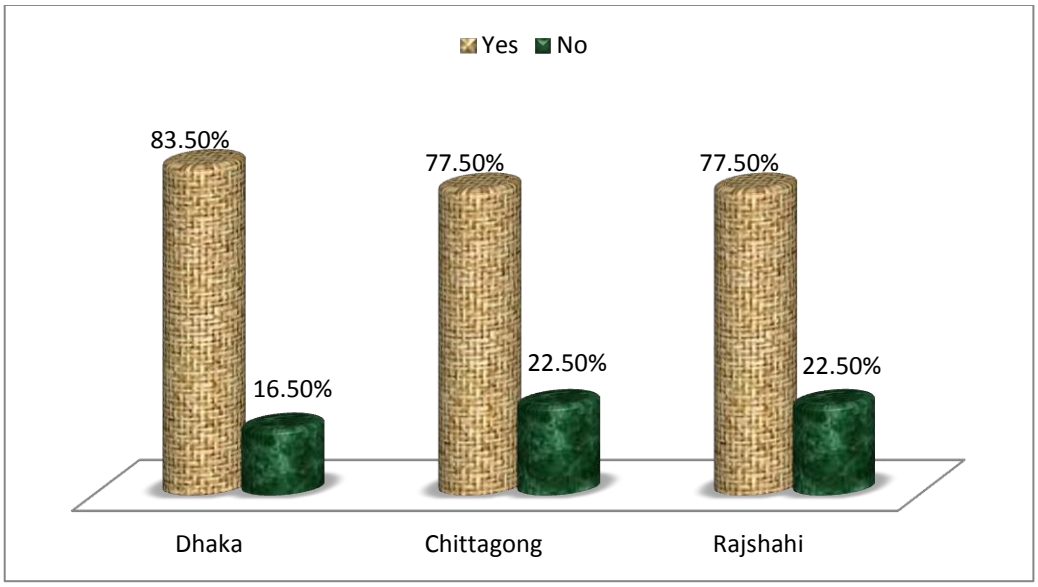


Figure 4.11: Junk food eating tendency

In Dhaka majority of the respondents eat junk food (83.50%). Rest of the respondents does not eat junk food (16.50%).

In Chittagong majority of the respondents eat junk food (77.50%). Rest of the respondents does not eat junk food (22.50%).

In Rajshahi majority of the respondents eat junk food (77.50%). Rest of the respondents does not eat junk food (22.50%).

4.12 Source of drinking water

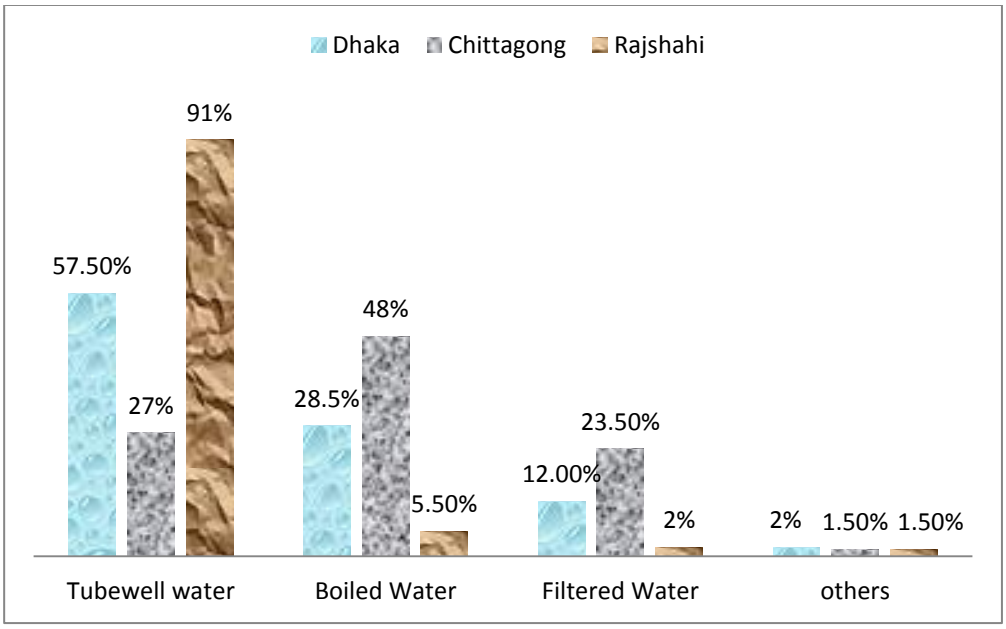


Figure: 4.12 Source of drinking water

In Dhaka among 200 respondents more than half respondents (57.86%) drink water from tube well, 28.50% drink boiled water, 12% drink filtered water, 2% drink water from other sources.

In Chittagong among 200 respondents almost half of the respondents (48%) drink boiled water, 27% drink water from tube well, 23.50% drink filtered water, 1.50% drink water from other sources.

In Rajshahi among 200 respondents majority of the respondents (91%) drink water from tube well, 5.50% drink boiled water, 2% drink filtered water, 1.50% drink water from other sources.

4.13 Sanitation Problem

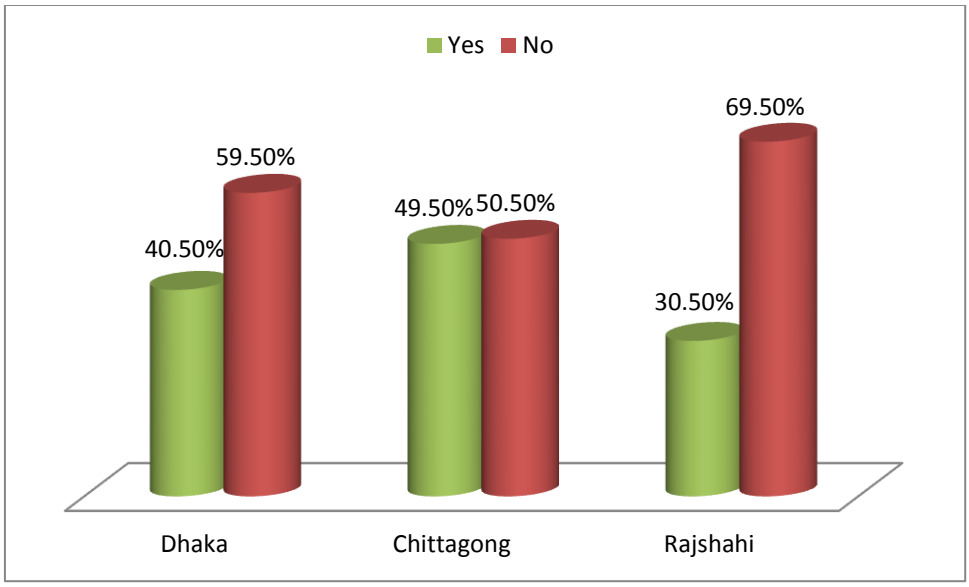


Figure 4.13: Sanitation Problem

In Dhaka majority of the respondents do not face sanitation problem (59.50%). Rest of the respondents face sanitation problem (40.50%).

In Chittagong half of the respondents do not face sanitation problem (50.50%). Rest of the respondents face sanitation problem (49.50%).

In Rajshahi majority of the respondents do not face sanitation problem (69.50%). Rest of the respondents face sanitation problem (30.50%).

4.14 Types of sanitation problems

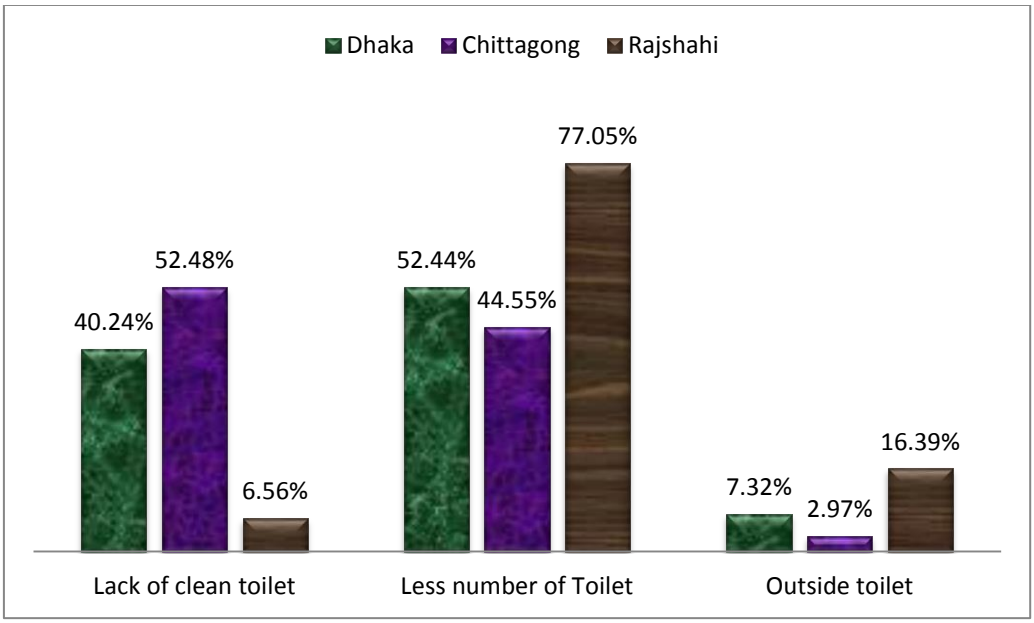


Figure 4.14: Types of sanitation problems

In Dhaka among 82 respondents who face sanitation problem 40.24% showed lack of clean toilet, 52.44% showed less number of toilet, 7.32% showed outside toilet as their types of sanitation problem.

In Chittagong among 101 respondents who face sanitation problem 52.48% showed lack of clean toilet, 44.55% showed less number of toilet, 2.97% showed outside toilet as their types of sanitation problem.

In Rajshahi among 61 respondents who face sanitation problem 77.05% showed less number of toilet, 13.39% showed outside toilet, 6.56% showed lack of toilet as their types of sanitation problem.

4.15 Hand washing tendency after using toilet

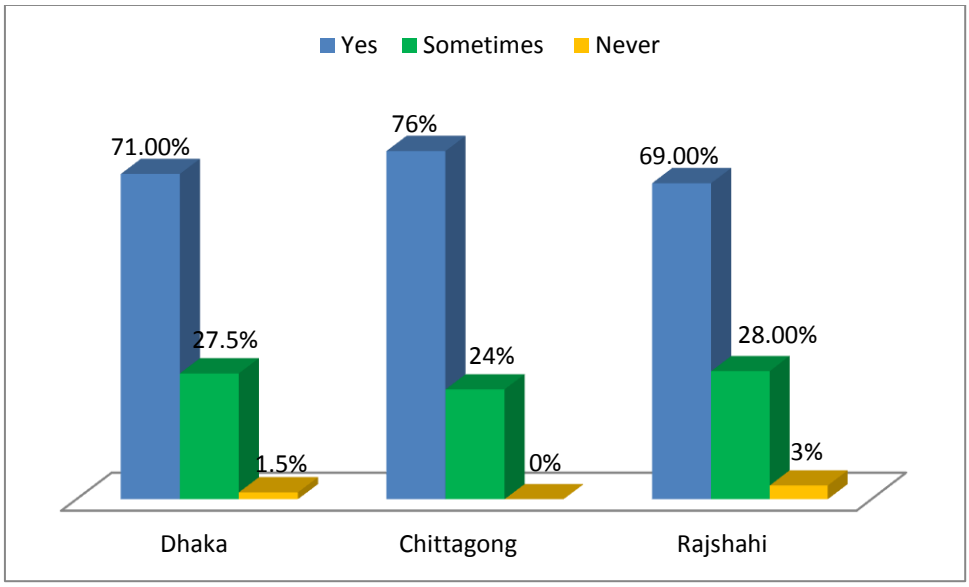


Figure 4.15: Hand washing tendency after using toilet

In Dhaka majority of the respondents wash their hands after using toilet (71%). 27.50% do not wash hands regularly after using toilet. 1.5% respondents never wash hands after using toilet.

In Chittagong majority of the respondents wash their hands after using toilet (76%). 24% do not wash hands regularly after using toilet. No respondent was found who never washes hands after using toilet.

In Rajshahi majority of the respondents wash their hands after using toilet (69%). 28% do not wash hands regularly after using toilet. 3% respondents never wash hands after using toilet.

4.16 Hand washing tendency before taking meal

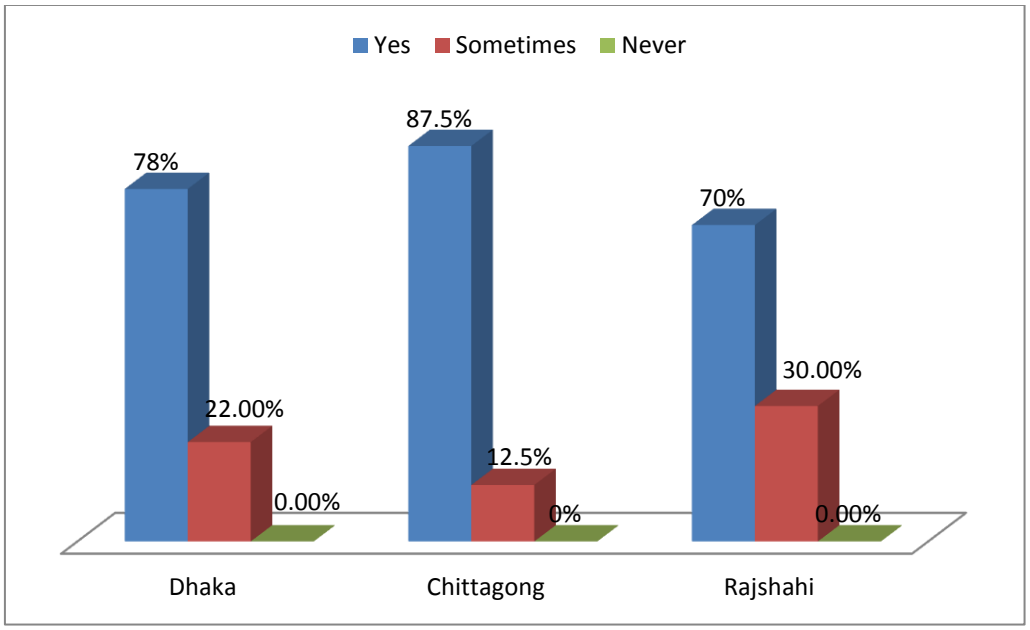


Figure 4.16: Hand washing tendency before taking meal

In Dhaka majority of the respondents wash their hands before taking meal (78%). 22% do not wash hands regularly before taking meal. No respondent was found who never washes hands before taking meal.

In Chittagong majority of the respondents wash their hands before taking meal (87.50%). 12.50% do not wash hands regularly before taking meal. No respondent was found who never washes hands before taking meal.

In Rajshahi majority of the respondents wash their hands before taking meal (70%). 30% do not wash hands regularly before taking meal. No respondent was found who never washes hands before taking meal.

4.17 Reason behind improper hand washing

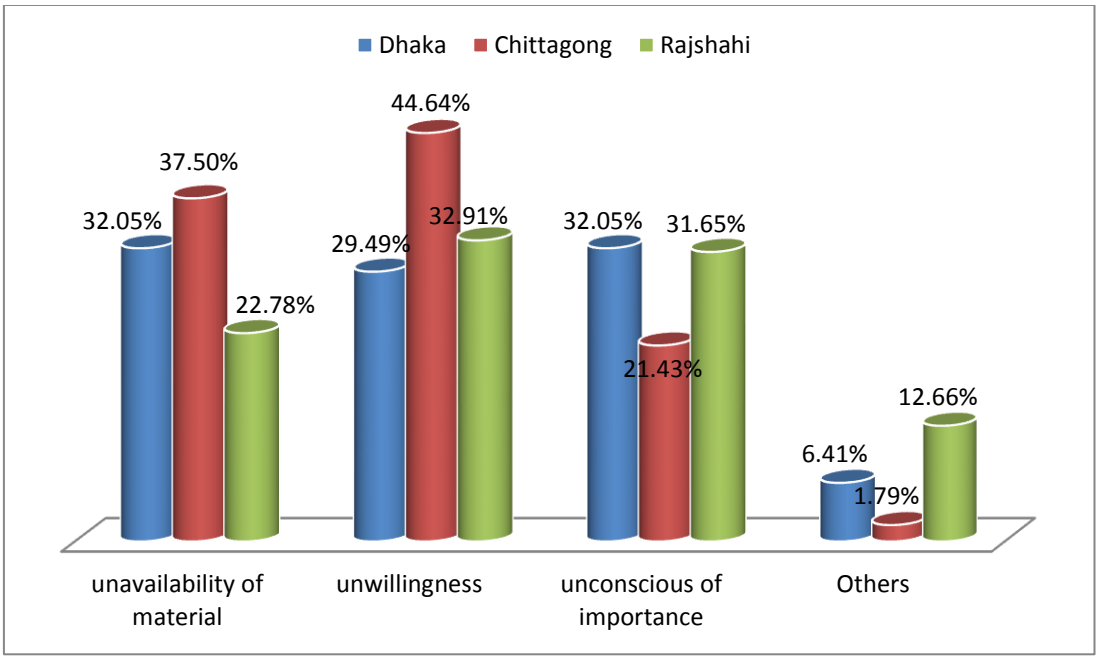


Figure 4.17: Reason behind improper hand washing

In Dhaka among 78 respondents who do not was hand after using toilet or before taking meal or both 32.05% showed unavailability of washing materials, 32.05% showed unconscious of importance, 29.49% showed unwillingness, 6.41% showed other reasons as their reason behind not washing hand properly.

In Chittagong among 56 respondents who do not was hand after using toilet or before taking meal or both 44.64% showed unavailability of washing materials, 32.05% showed unconscious of importance, 29.49% showed unwillingness, 1,79% showed other reasons as their reason behind not washing hand properly.

In Rajshahi among 79 respondents who do not was hand after using toilet or before taking meal or both 32.91% showed unwillingness, 31.65% showed unconscious of importance, 22.78% unavailability of washing materials, 12.66% showed other reasons as their reason behind not washing hand properly.

4.18 Sleeping duration

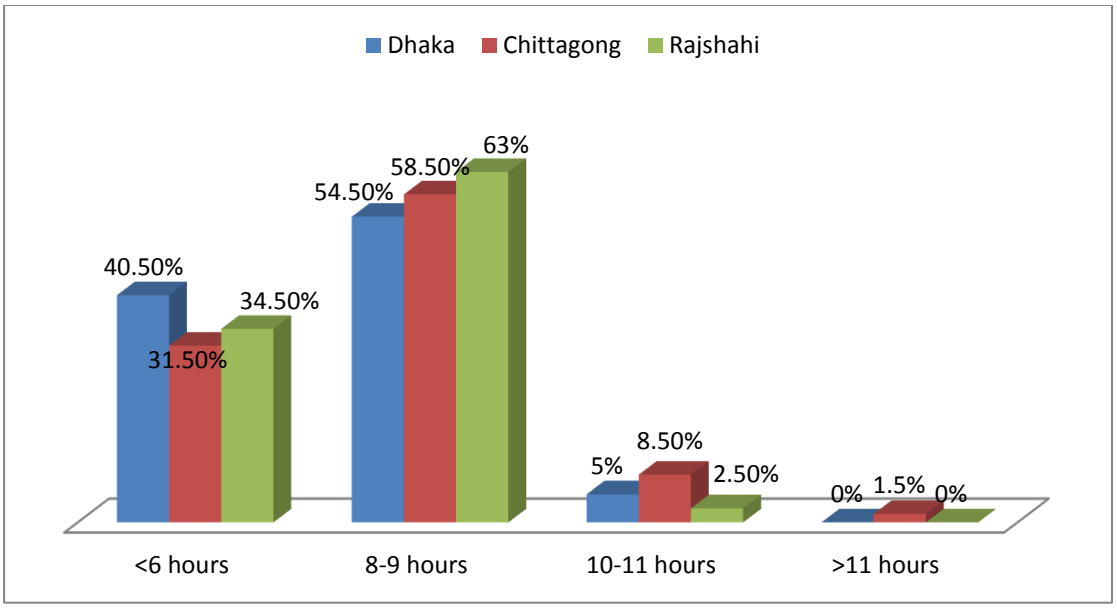


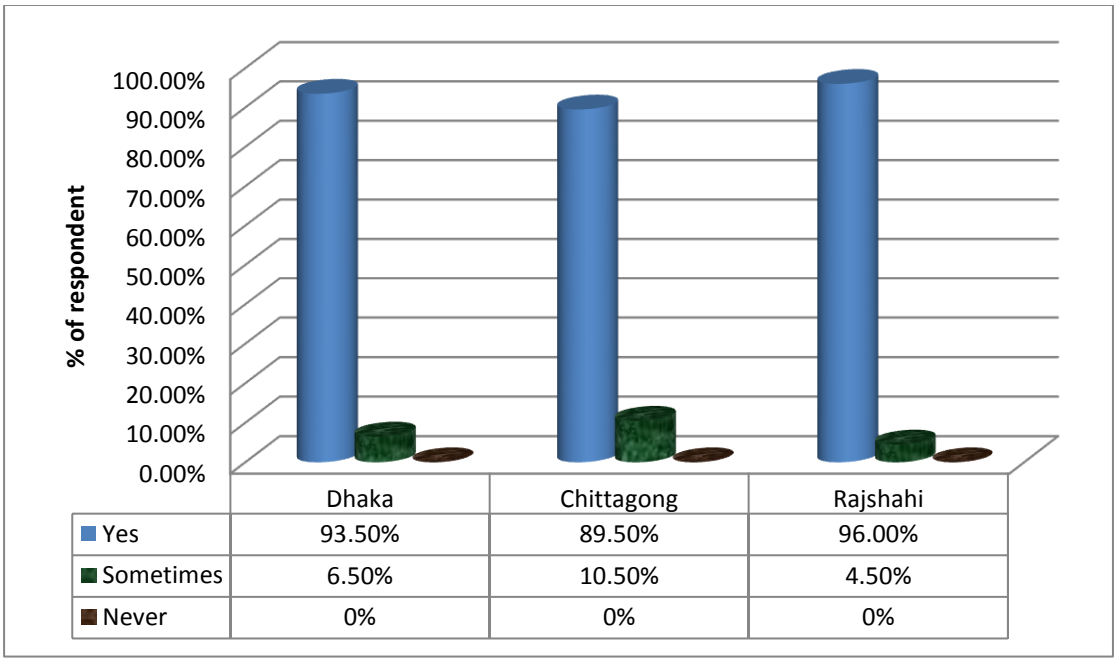
Figure 4.18: Sleeping duration

In Dhaka more than half of the respondents sleep 8-9 hours per day (54.50%), 40.50% sleeps less than 6 hours, 5% sleep for 10-11 hours. No respondent was found who sleeps more than 11 hours in a day.

In Chittagong more than half of the respondents sleep 8-9 hours per day (58.50%), 31.50% sleeps less than 6 hours, 8.50% sleep for 10-11 hours and 1.50% sleep for more than 11 hours per day.

In Rajshahi majority of the respondents sleep 8-9 hours per day (63%), 34.50% sleeps less than 6 hours, 2.50% sleep for 10-11 hours. No respondent was found who sleeps more than 11 hours in a day.

4.19 Tooth cleaning



	Dhaka	Chittagong	Rajshahi
Yes	93.50%	89.50%	96.00%
Sometimes	6.50%	10.50%	4.50%
Never	0%	0%	0%

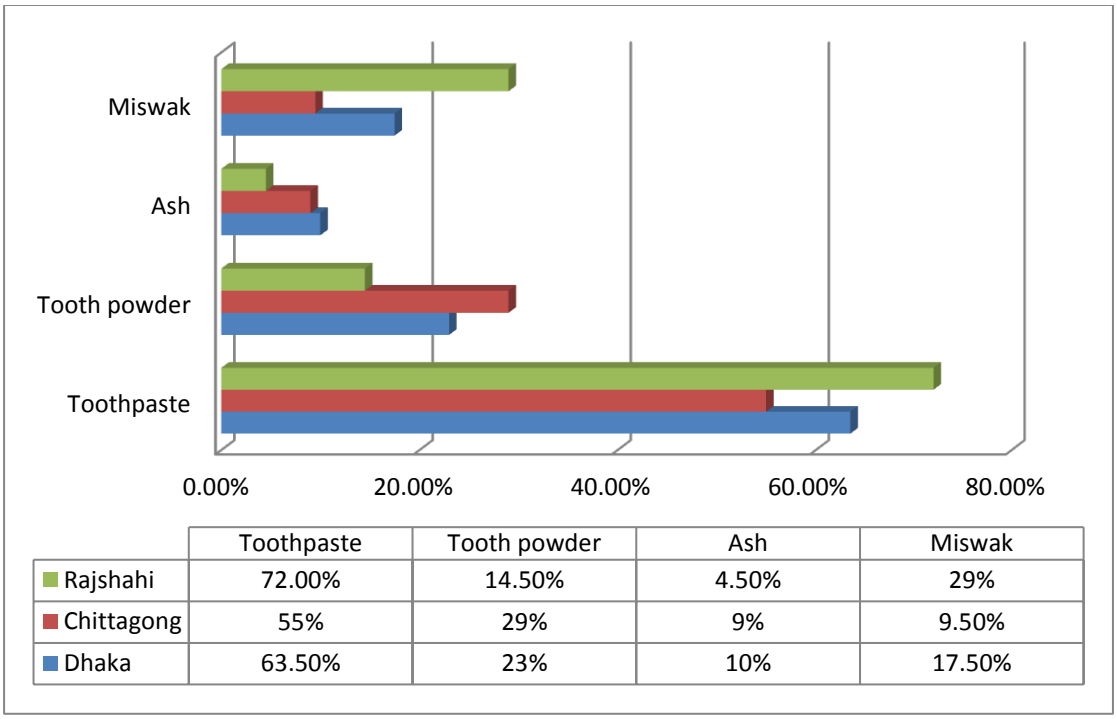
Figure 4.19: Tooth cleaning tendency

In Dhaka majority of the respondents clean teeth regularly (93.50%). 6.50% do not clean teeth regularly. No respondent was found who never clean teeth.

In Chittagong majority of the respondents clean teeth regularly (89.50%). 10.50% do not clean teeth regularly. No respondent was found who never clean teeth.

In Rajshahi majority of the respondents clean teeth regularly (96.50%). 4.50% do not clean teeth regularly. No respondent was found who never clean teeth.

4.20 Measure of cleaning tooth



	Toothpaste	Tooth powder	Ash	Miswak
Rajshahi	72.00%	14.50%	4.50%	29%
Chittagong	55%	29%	9%	9.50%
Dhaka	63.50%	23%	10%	17.50%

Figure 4.20: Measure of cleaning tooth

In Dhaka majority of the respondents (63.50%) use toothpaste, 23% use toothpowder, 17.50% use miswak, 10% use ash for cleaning teeth.

In Chittagong more than half of the respondents (55%) use toothpaste, 29% use toothpowder, 9.50% use miswak, 9% use ash for cleaning teeth.

In Rajshahi majority of the respondents (72%) use toothpaste, 14.50% use toothpowder, 29% use miswak, 4.50% use ash for cleaning teeth.

4.21 Duration of playing Games/ taking physical exercise

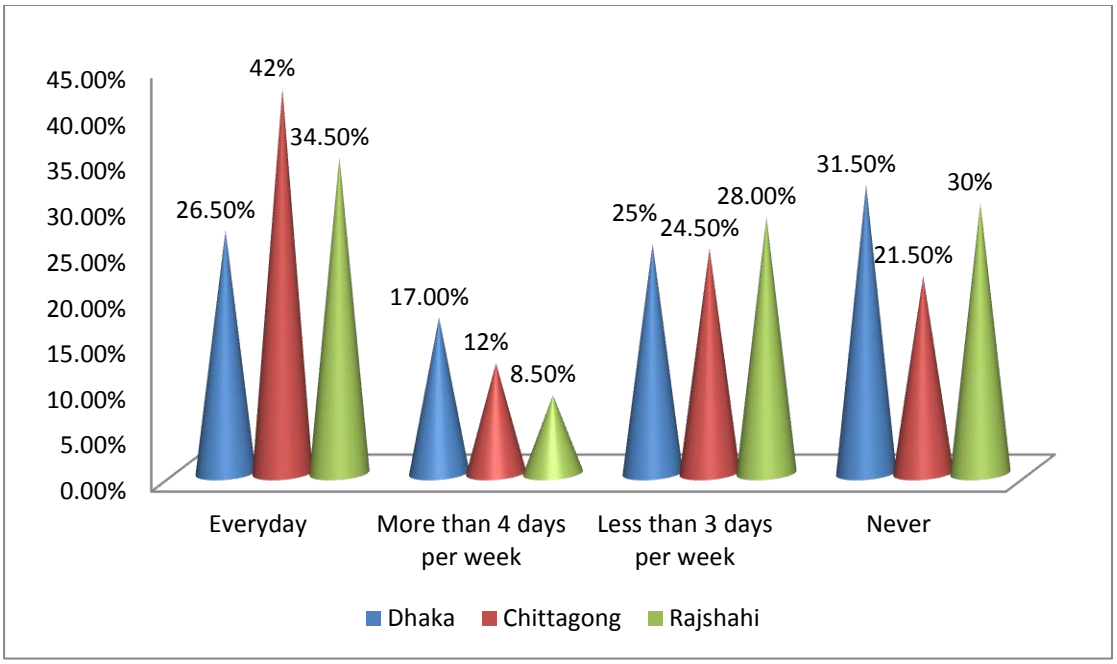


Figure 4.21: Duration of playing Games/ taking physical exercise

In Dhaka 31.50% respondents never play games or take physical exercise, 26.50% play every day, 25% play less than 3 days per week. 17% respondents play more than 4 days per week.

In Chittagong 42% respondents play every day, 24.50% play less than 3 days per week, 21.50% play never and 12% respondents play more than 4 days per week.

In Rajshahi 34.50% respondents play every day, 30% play games or take physical exercise never, 28% play less than 3 days per week. 8.50% respondents play more than 4 days per week.

4.22 Playground Facilities

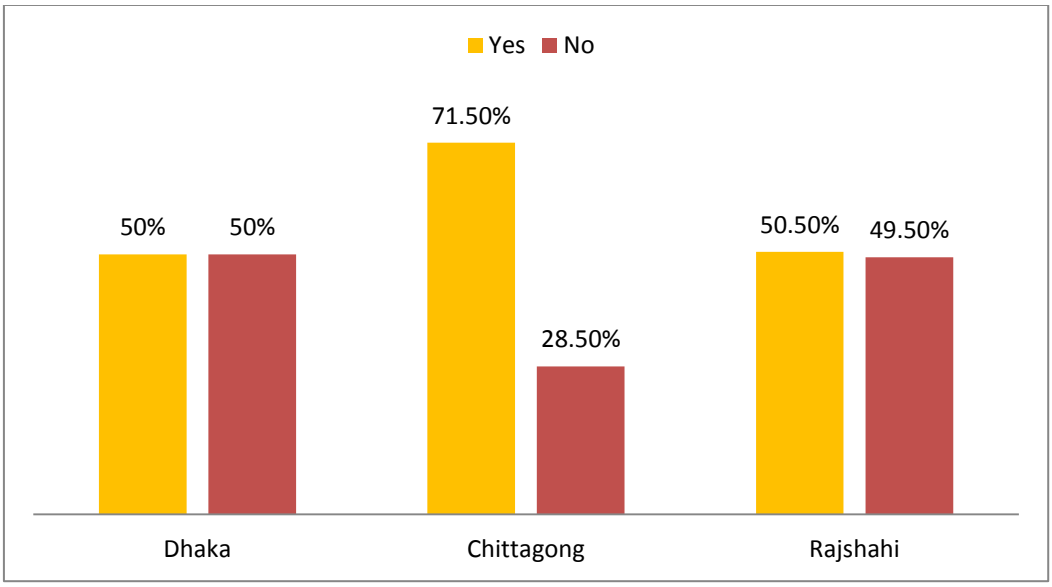


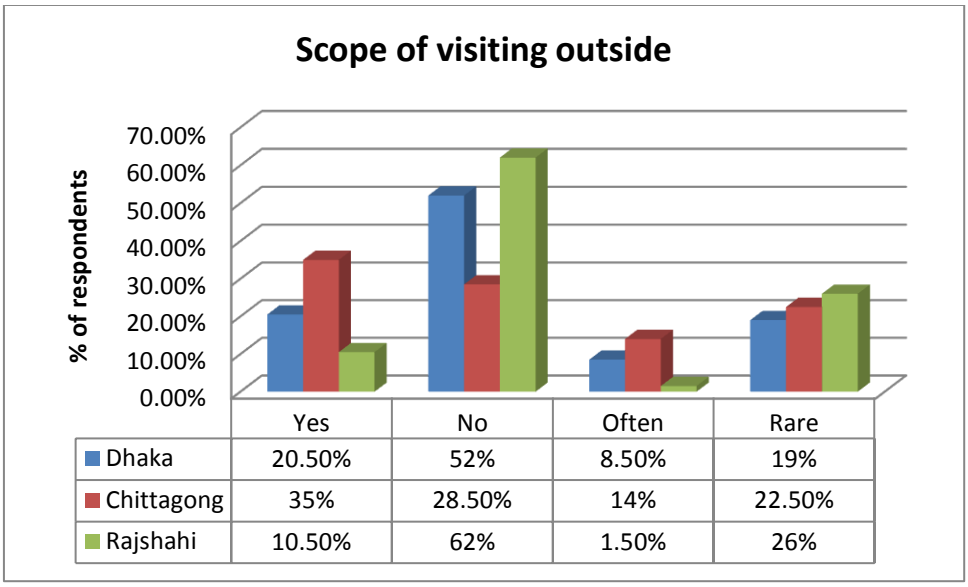
Figure 4.22: Playground Facilities

In Dhaka half of the respondents have playground facilities (50%) and half of the respondents do not have playground facilities (50%).

In Chittagong majority of the respondents have playground facilities (71.50%) and rest of the respondents do not have playground facilities (28.50%).

In Rajshahi almost half of the respondents have playground facilities (50.50%) and rest of the respondents do not have playground facilities (49.50%).

4.23 Scope of vesting outside



	Yes	No	Often	Rare
Dhaka	20.50%	52%	8.50%	19%
Chittagong	35%	28.50%	14%	22.50%
Rajshahi	10.50%	62%	1.50%	26%

Figure 4.23: Scope of vesting outside

In Dhaka almost half of the respondents do not have the scope of visiting amusement park, going picnic etc. (52%). 20.50% respondents have the facilities of going outside regularly,19% respondents have this scope rare and8.50% have this scope of visiting outside often.

In Chittagong almost half of the respondents have the scope of visting outside regularly(35%), 28.50% respondents do not have the facilities of going outside, 22.50% respondents have this scope rare and 14% have this scope of visiting outside often.

In Rajshahi majority of the respondents do not have the scope of visiting amusement park, going picnic etc. (62%). 26% respondents have the facilities of going outside rare,10.50% respondents have this scope refularly and 1.50% have this scope of visiting outside often.

4.24 Suffering from disease

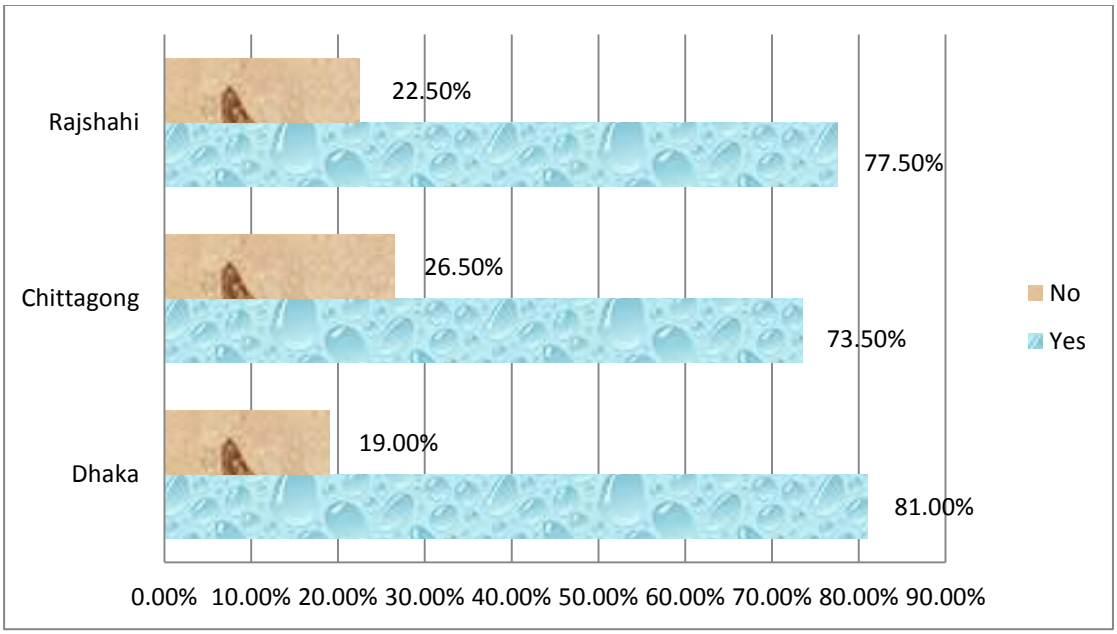


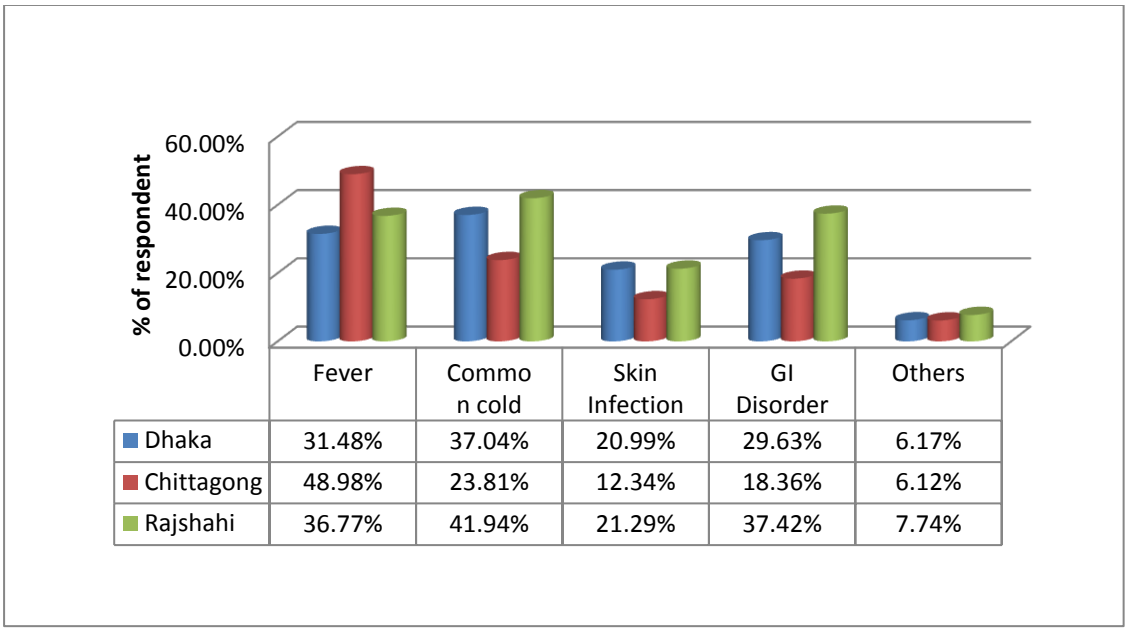
Figure 4.24: Suffering from disease during last six months

In Dhaka majority of the respondents suffered from diseases during last 6 months (81%) and rest of the respondents did not suffer from (19%).

In Chittagong majority of the respondents suffered from diseases during last 6 months (73.50%) and rest of the respondents did not suffer from (26.50%).

In Rajshahi majority of the respondents suffered from diseases during last 6 months (77.50%%) and rest of the respondents did not suffer from diseases (22.50%).

4.25 Disease pattren



	Fever	Common cold	Skin Infection	GI Disorder	Others
Dhaka	31.48%	37.04%	20.99%	29.63%	6.17%
Chittagong	48.98%	23.81%	12.34%	18.36%	6.12%
Rajshahi	36.77%	41.94%	21.29%	37.42%	7.74%

Figure 4.25: Sort of illness during last six months

In Dhaka among 162 respondents who suffered from diseases during last 6 months 37.48% suffered from common cold, 31.48% suffered from fever, 29.63% suffered from GI disorder, 20.99% suffered from skin infection and 6.17% suffered from other diseases.

In Chittagong among 147 respondents who suffered from diseases during last 6 months 48.98% suffered from fever, 23.81% suffered from common cold, 18.36% suffered from GI disorder, 12.34% suffered from skin infection and 6.12% suffered from other diseases.

In Rajshahi among 155 respondents who suffered from diseases during last 6 months 41.94% suffered from common cold, 37.42% suffered from GIT disorder, 36.77% suffered from fever, 21.29% suffered from skin infection and 7.74% suffered from other diseases.

4.26 Measures taken to cure from illness

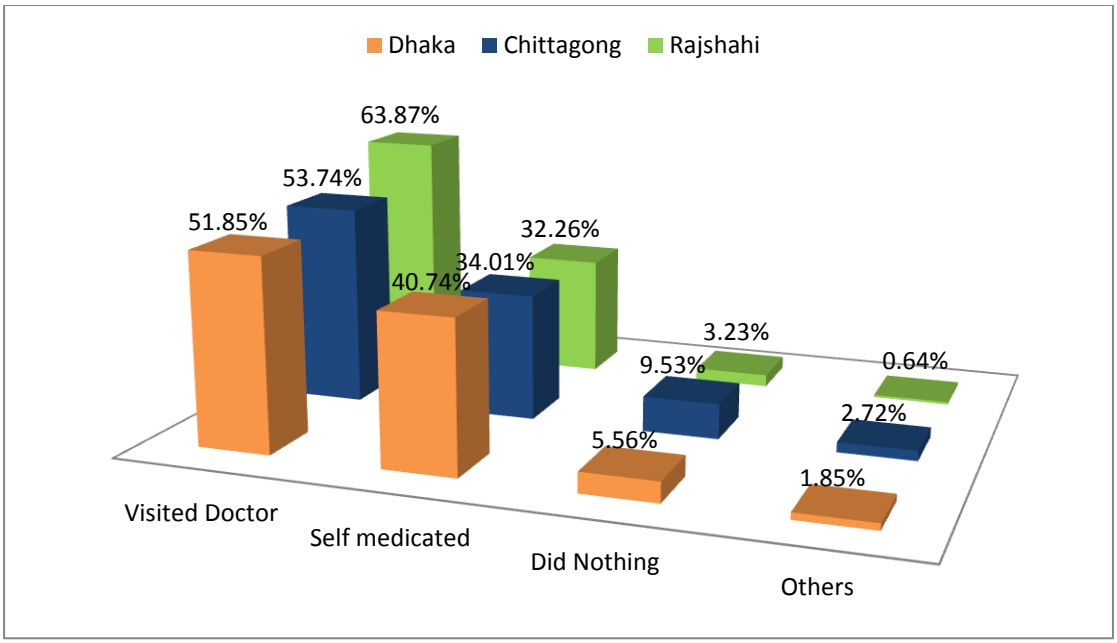


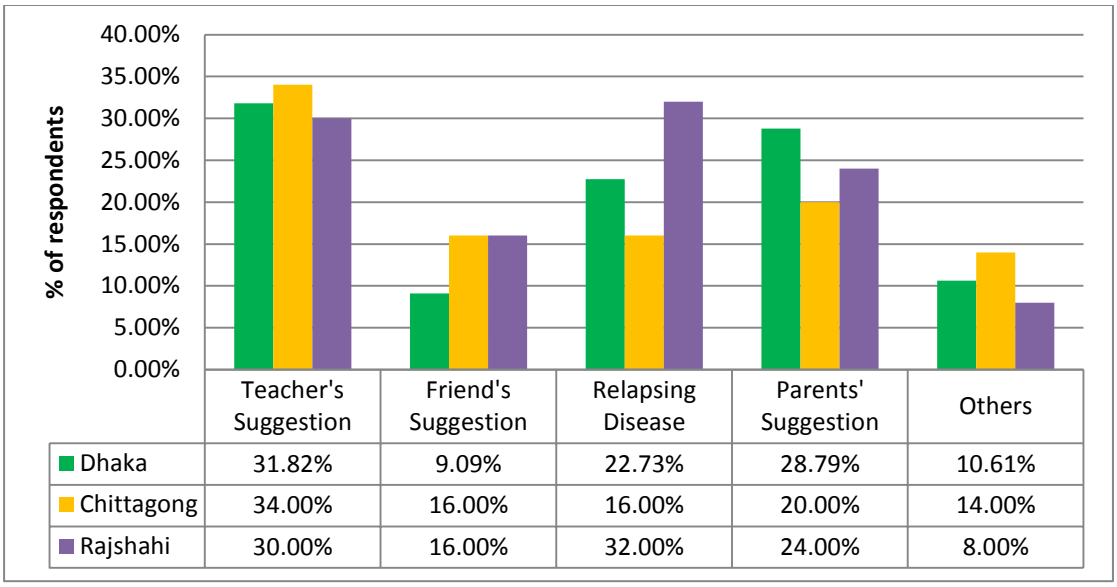
Figure 4.26: Measures taken to cure from illness

In Dhaka among 162 respondents who suffered from diseases during last 6 months half of the respondents (51.85%) visited doctor, 40.74% used self-medication, 5.56% didn't take any measure, 1.85% took other steps.

In Chittagong among 147 respondents who suffered from diseases during last 6 months more than half of the respondents(53.74%) visited doctor, 34.01% used self-medication, 9.53% didn't take any measure, and 2.72% took other steps.

In Rajshahi among 155 respondents who suffered from diseases during last 6 months majority of the respondents(63.87%) visited doctor, 40.74% used self-medication, 5.56% didn't take any measure and 1.85% took other steps.

4.27 Reason behind self-medication



	Teacher's Suggestion	Friend's Suggestion	Relapsing Disease	Parents' Suggestion	Others
Dhaka	31.82%	9.09%	22.73%	28.79%	10.61%
Chittagong	34.00%	16.00%	16.00%	20.00%	14.00%
Rajshahi	30.00%	16.00%	32.00%	24.00%	8.00%

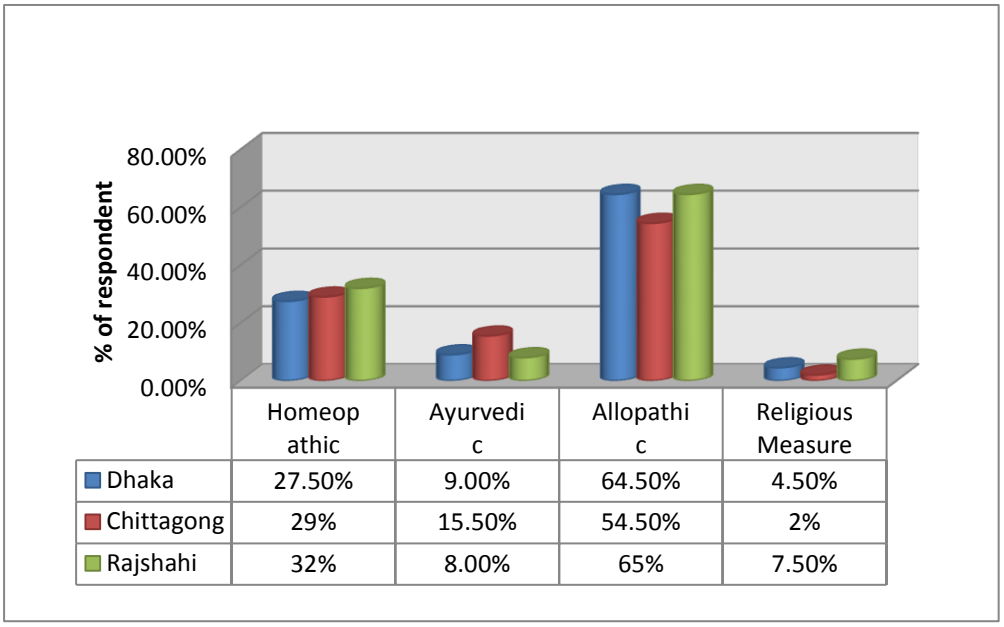
Figure 4.27 Reason behind self-medication

In Dhaka among 66 respondents who used self-medication as treatment of diseases31.82% showed teacher's suggestion , 28.79% showed parents' suggestion, 22.73% showed relapsing of disease, 10.61% showed others and 9.09% showed friend's suggestion as their reason behind self-medication.

In Chittagong among 50 respondents who used self-medication as treatment of diseases 34% showed teacher's suggestion,20% showed parents' suggestion, 16% showed relapsing of disease, 16% showed friend's suggestion and 14% showed others as their reason behind self-medication.

In Rajshahi among 50 respondents who used self-medication as treatment of diseases 32% showed relapsing diseases, 30% showed teacher's suggestion, 24% showed parents' suggestion, 16% showed friend's suggestion and 8% showed others as their reason behind self-medication.

4.28 Usual treatment of illness



	Homeopathic	Ayurvedic	Allopathic	Religious Measure
Dhaka	27.50%	9.00%	64.50%	4.50%
Chittagong	29%	15.50%	54.50%	2%
Rajshahi	32%	8.00%	65%	7.50%

Figure 4.28: Usual treatment of illness

In Dhaka most of the respondents took allopathic as their usual treatment (64.50%), 27.50% of the respondents took homeopathic as their usual treatment, 9.00% of the respondents took ayurvedic as their usual treatment and 4.50% of the respondents took religious measure as their usual treatment.

In Chittagong almost half of the respondents took allopathic as their usual treatment (54.50%), 29% of the respondents took homeopathic as their usual treatment, 15.50% of the respondents took ayurvedic as their usual treatment and 2% of the respondents took religious measure as their usual treatment.

In Rajshahi most of the respondents took allopathic as their usual treatment (65%), 32% of the respondents took homeopathic as their usual treatment, 8.00% of the respondents took ayurvedic as their usual treatment and 7.50% of the respondents took religious measure as their usual treatment.

4.29 Tendency of curing illness

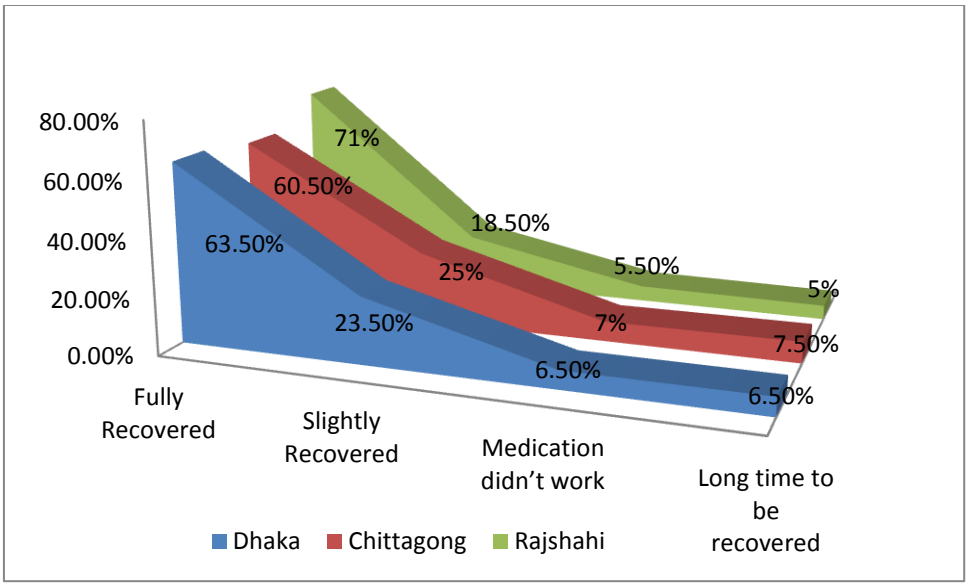


Figure 4.29: Tendency of curing illness

In Dhaka after taking treatment majority of respondents recovered from illness (63.50%), 23.50% were slightly recovered, 6.50% respondents showed the medication didn't work and 6.50% respondents faced long time to be recovered from illness.

In Chittagong after taking treatment majority of respondents recovered from illness (60.50%), 25% were slightly recovered, 7.50% respondents faced long time to be recovered from illness and 7% respondents showed the medication didn't work.

In Rajshahi after taking treatment majority of respondents recovered from illness (71%), 18.50% were slightly recovered, 5.50% respondents showed the medication didn't work and 5% respondents faced long time to be recovered from illness.

4.30 Feeling safe in the institution during illness

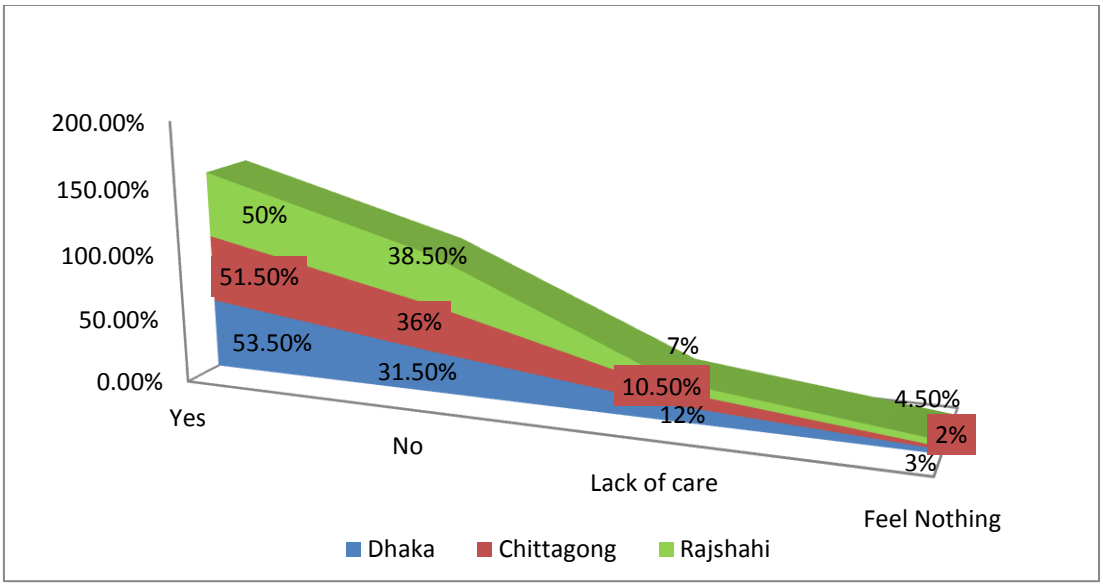


Figure 4.30: Feeling safe in the institution during illness

In Dhaka more than half of the respondents feel safe in the institution when they become ill (53.50%). 31.50% do not feel safe, 12% feel lack of care and 3% feel nothing.

In Chittagong more than half of the respondents feel safe in the institution when they become ill (51.50%). 36% do not feel safe, 10.50% feel lack of care and 2% feel nothing.

In Rajshahi half of the respondents feel safe in the institution when they become ill (50%). 38.50% do not feel safe, 7% feel lack of care and 4.50% feel nothing.

4.31 Knowledge about vaccination

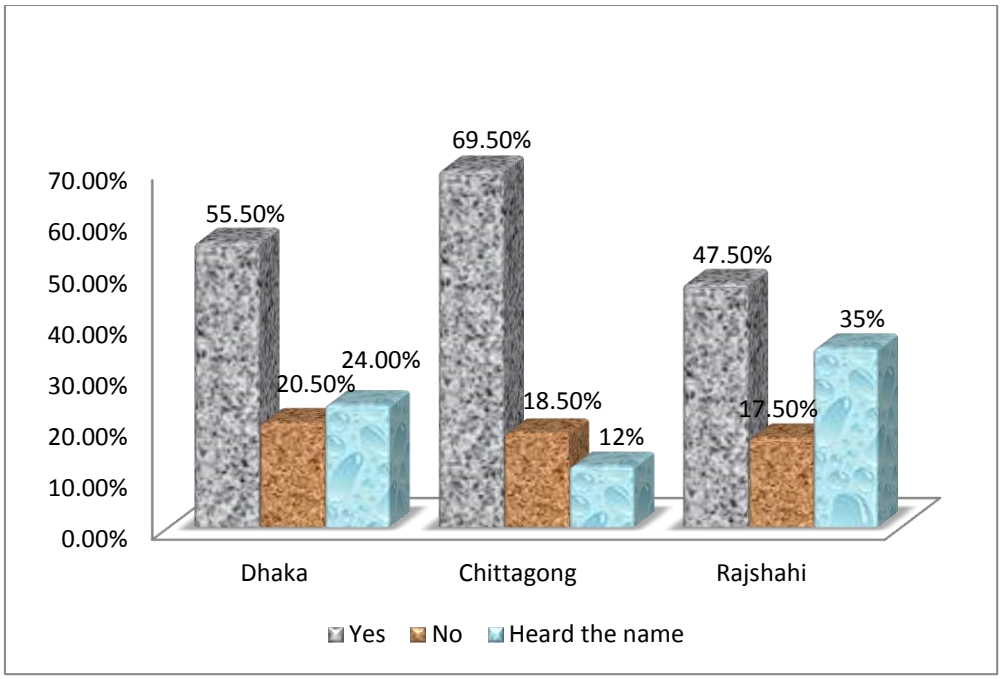


Figure 4.31: Knowledge about vaccination

In Dhaka almost half of the respondents have knowledge about vaccination (55.50%), 24.00% of the respondents heard the name of the vaccination and 20.50% of the respondents did not have the knowledge about vaccination.

In Chittagong most of the respondents have the knowledge about vaccination (69.50%), 18.50% of the respondents did not have the knowledge about vaccination and 12% of the respondents heard the name of the vaccination.

In Rajshahi almost half of the respondents have knowledge about vaccination (47.50%), 35% of the respondents heard the name of the vaccination and 17.50% of the respondents did not have the knowledge about vaccination

4.32 Taking Vaccination

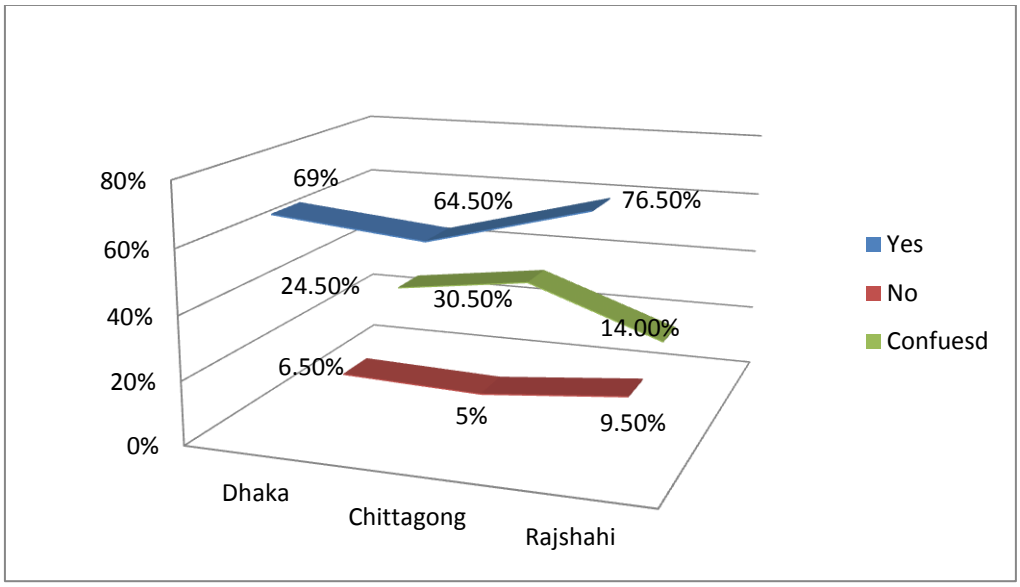


Figure 4.32: Taking Vaccination

In Dhaka most of the respondents have taken vaccination (69%), 24.50% of the respondents were confused about taking vaccination and 6.50% of the respondents did not take any vaccination.

In Chittagong most of the respondents have taken vaccination (64.50%), 30.50% of the respondents were confused about taking vaccination and 5% of the respondents did not take any vaccination.

In Rajshahi most of the respondents have taken vaccination (76.50%), 14.00% of the respondents were confused about taking vaccination and 9.50% of the respondents did not take any vaccination.

4.33 Suffering from Chronic disease

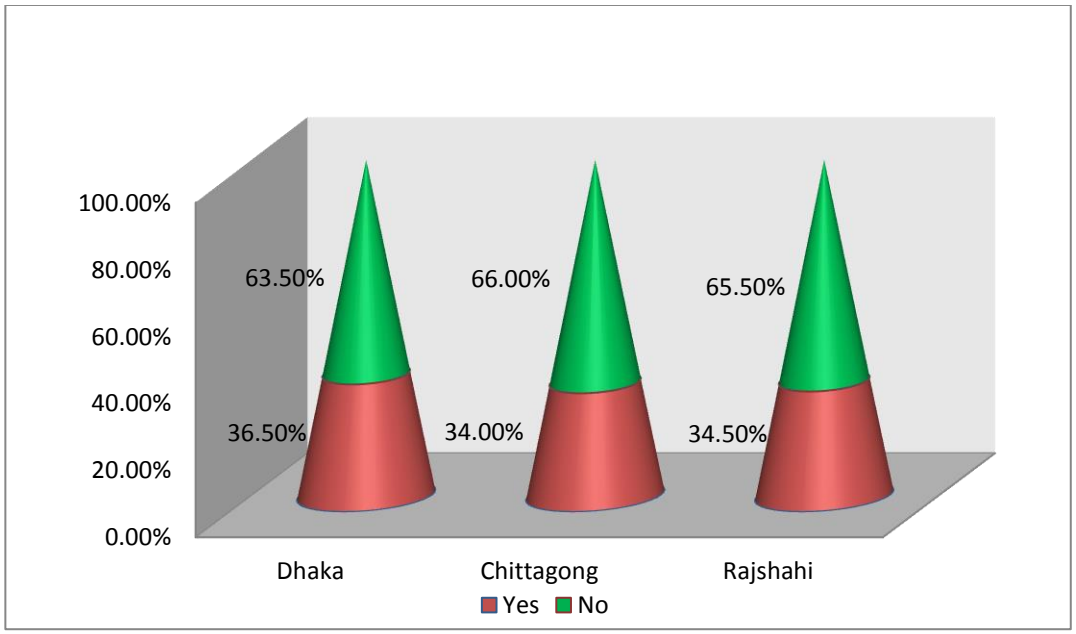


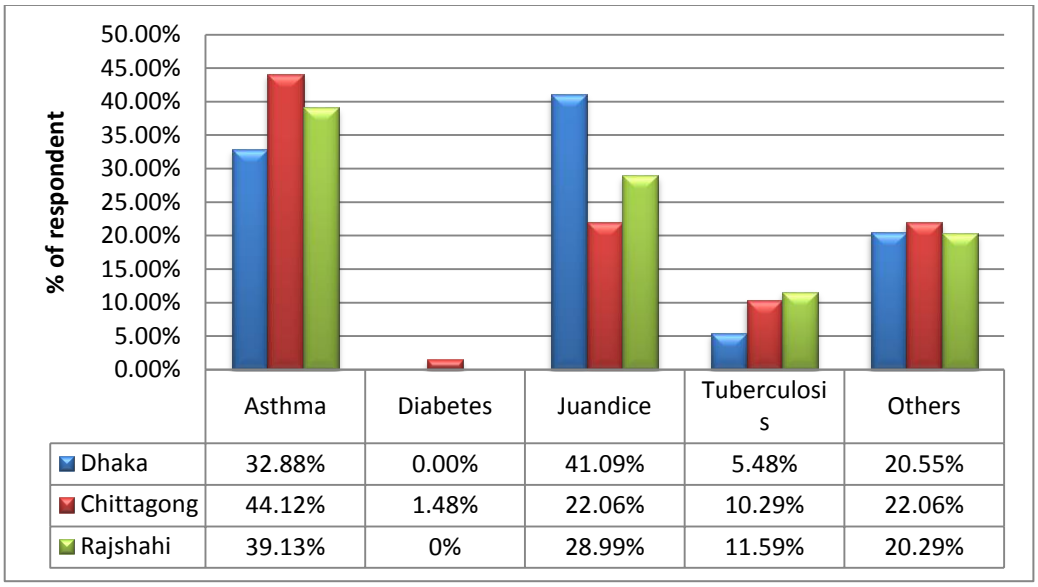
Figure 4.33: Suffering from Chronic disease

In Dhaka 63.50% respondents suffered from chronic diseases and rest of the respondents did not suffer from chronic disease (36.50%).

In Chittagong 66% respondents suffered from chronic diseases and rest of the respondents did not suffer from chronic disease (34%).

In Rajshahi 65.50% respondents suffered from chronic diseases and rest of the respondents did not suffer from chronic disease (34.50%).

4.34 Types of Chronic disease



	Asthma	Diabetes	Juandice	Tuberculosis	Others
Dhaka	32.88%	0.00%	41.09%	5.48%	20.55%
Chittagong	44.12%	1.48%	22.06%	10.29%	22.06%
Rajshahi	39.13%	0%	28.99%	11.59%	20.29%

Figure 4.34: Types of Chronic disease

In Dhaka among 73 respondents having chronic disease most of the respondents were suffering from jaundice (41.09%), 32.88% of the respondents were suffering from asthma, 20.55% of the respondents were suffering from other chronic diseases, 5.48% of the respondents were suffering from tuberculosis and No respondents were found to suffer from diabetes.

In Chittagong among 68 respondents having chronic disease almost half of the respondents were suffering from asthma (44.12%), 22.06% of the respondents were suffering from jaundice, 22.06% of the respondents were suffering from ot he chronic disease, 10.29% of the respondents were suffering from tuberculosis and 1.48% of the respondents were suffering from diabetes.

In Rajshahi among 69 respondents having chronic disease most of the respondents were suffering from asthma (39.13%), 28.99% of the respondents were suffering from jaundice, 20.29% of the respondents were suffering from others chronic diseases,11.59% of the respondents were suffering from tuberculosis and No respondents were found to suffer from diabetes.

4.35 Knowledge about health service right

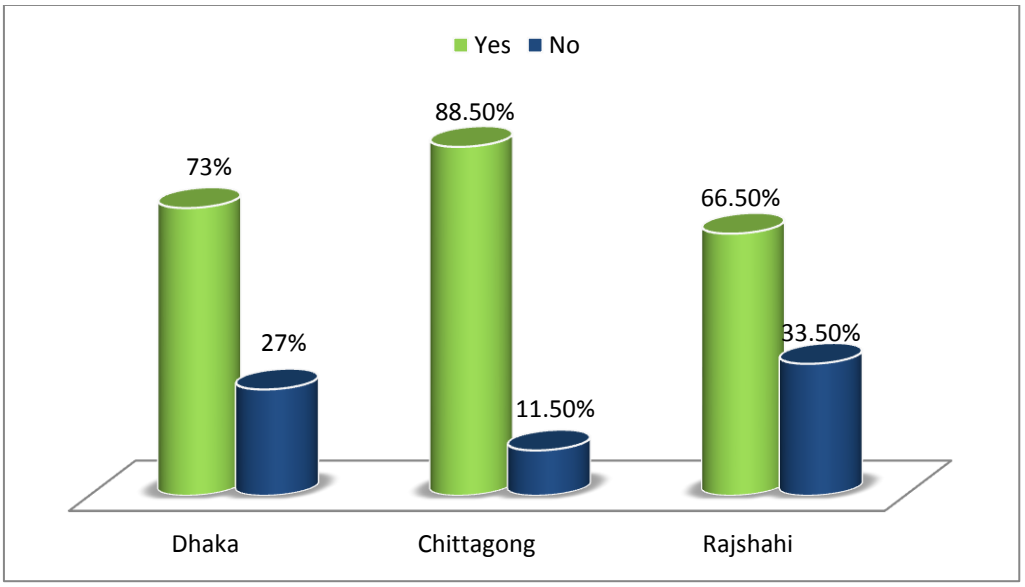


Figure 4.35: Knowledge about health service right

In Dhaka most of the respondents had knowledge about health service right (73%) and 27% of the respondents did not have the knowledge about health service right.

In Chittagong most of the respondents had knowledge about health service right (88.50%) and 11.50% of the respondents did not have the knowledge about health service right.

In Rajshahi most of the respondents had knowledge about health service right (66.50%) and 33.50% of the respondents did not have the knowledge about health service right.

4.36 Deprivation of health service

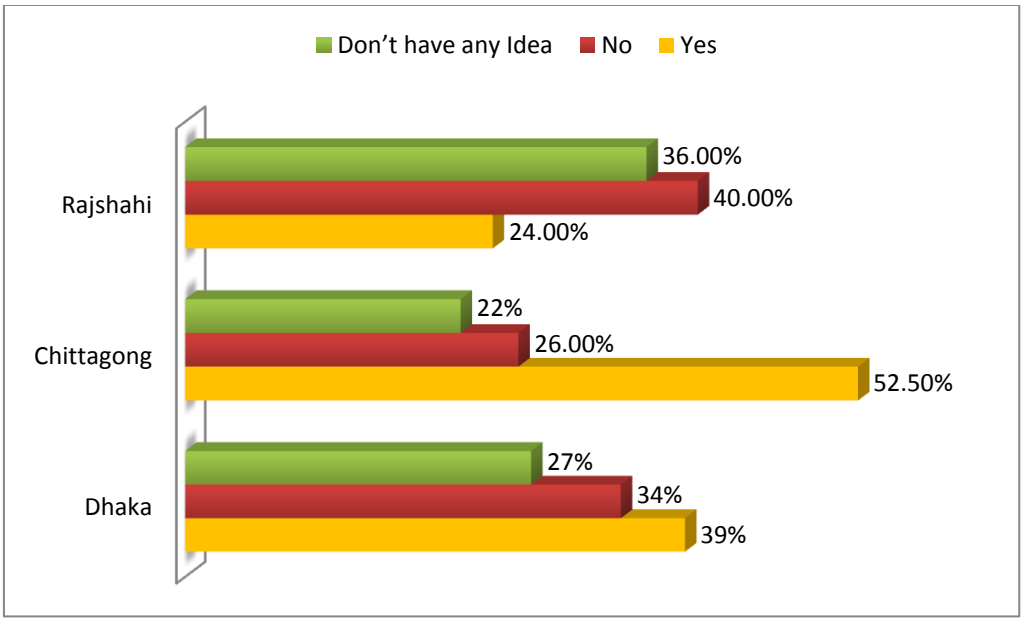


Figure 4.36: Deprivation of health service

In Dhaka 39% of the respondents were deprived of health service, 34% of the respondents were not deprived of health service and 27% of the respondents did not have any idea about health service.

In Chittagong almost half of the respondents were deprived of health service (52.50%), 26.00% of the respondents were not deprived of health service and 22% of the respondents did not have any idea about health service.

In Rajshahi 40.00% of the respondents were not deprived of health service, 36.00% of the respondents did not have any idea about health service and 24.00% were deprived of health service.

4.37 Yearly health checkup

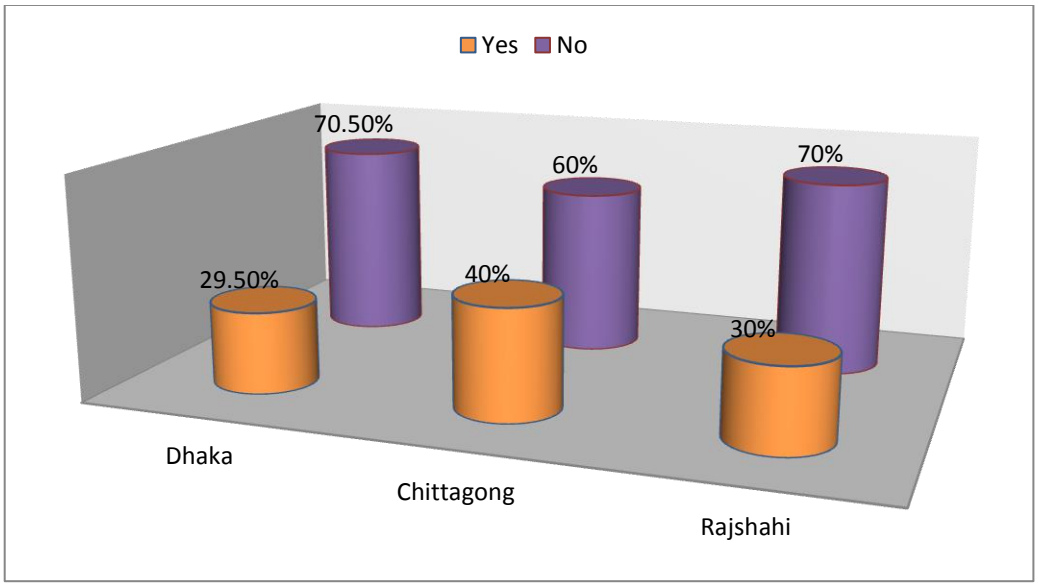


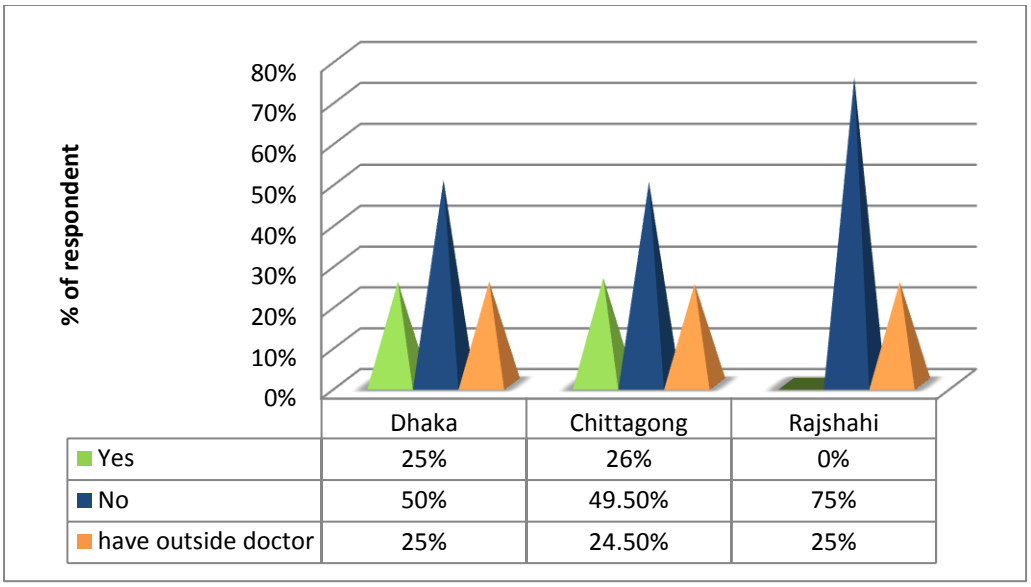
Figure 4.37: Yearly health checkup

In Dhaka most of the respondents do yearly health checkup (70.50%) and 29.50% of the respondents do not do yearly health checkup.

In Chittagong most of the respondents do yearly health checkup (60%) and 40% of the respondents do not do yearly health checkup.

In Rajshahi most of the respondents do yearly health checkup (70%) and 30% of the respondents do not do yearly health checkup

4.38 Healthcare professional



	Dhaka	Chittagong	Rajshahi
Yes	25%	26%	0%
No	50%	49.50%	75%
have outside doctor	25%	24.50%	25%

Figure 4.38: Healthcare professional

In Dhaka half of the respondents did not have healthcare professionals (50%), 25% of the respondents had healthcare professionals and 25% of the respondents had outside doctors.

In Chittagong almost half of the respondents did not have healthcare professionals (49.50%), 26% of the respondents had healthcare professionals and 24.50% of the respondents had outside doctors.

In Rajshahi most of the respondents did not have healthcare professionals (75%) and 25% of the respondents had outside doctors.

4.39 Preferable people to share problem

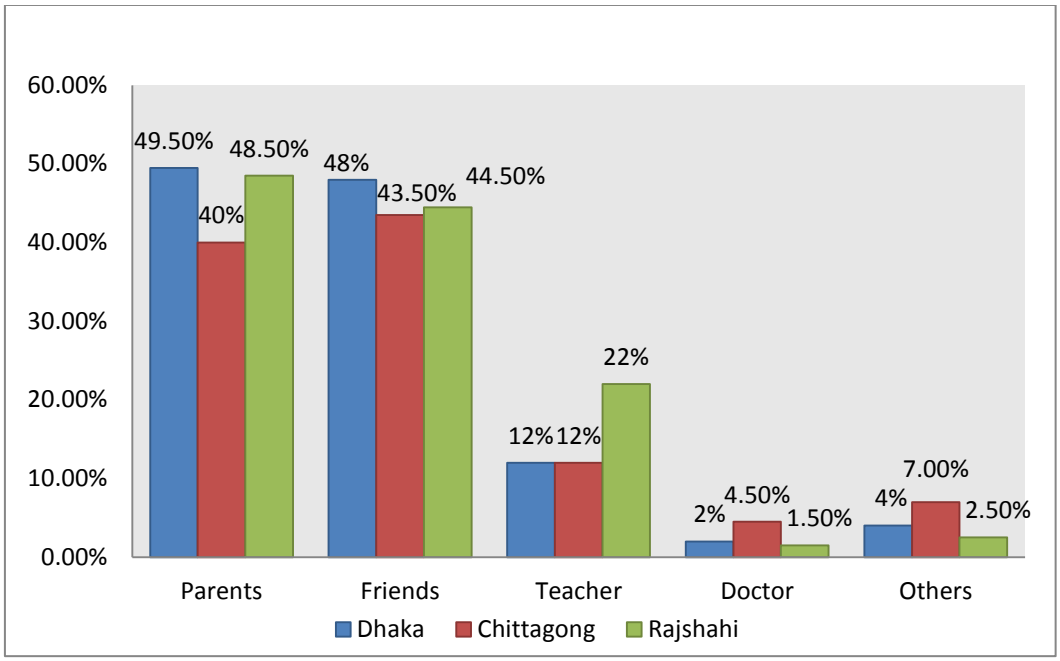


Figure 4.39 Preferable people to share problem

In Dhaka 49.50% of the respondents share personal problems with their parents, 48% of the respondents share personal problems with their friends, 12% of the respondents share personal problems with their teachers, 4% of the respondents share personal problems with others and 2% of the respondents share their personal problems with their doctors.

In Chittagong 43.50% of the respondents share personal problems with their friends, 40% of the respondents share personal problems with their parents, 12% of the respondents share personal problems with their teachers, 7% of the respondents share personal problems with others and 4.50% of the respondents share their personal problems with their doctors.

In Rajshahi 48.50% of the respondents share personal problems with their parents, 44.50% of the respondents share personal problems with their friends, 22% of the respondents share personal problems with their teachers, 2.50% of the respondents share personal problems with others and 1.50% of the respondents share their personal problems with their doctors.

4.40 Personal problem

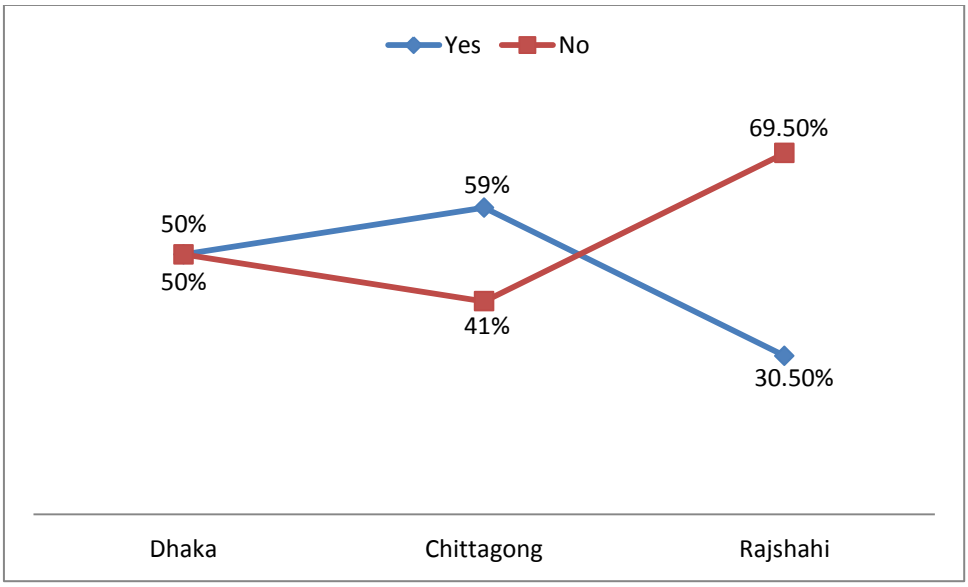


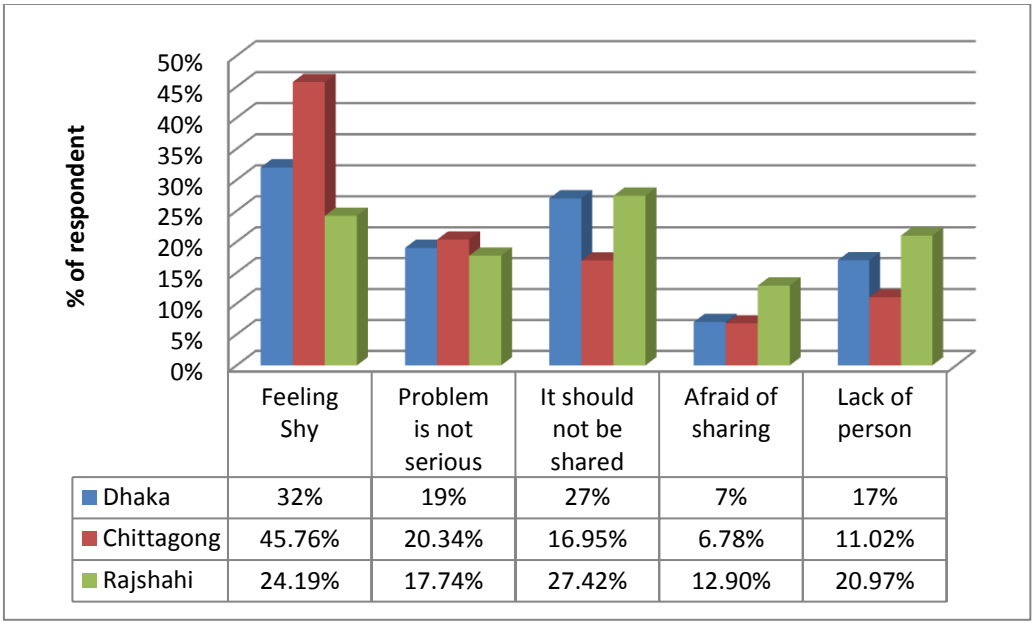
Figure 4.40: Personal problem cannot be shared

In Dhaka half of the respondents have personal problem that cannot be shared (50%) and rest of the respondents do not have personal problems that cannot be shared (50%).

In Chittagong most of the respondents have personal problem that cannot be shared (59%) and 41% of the respondents do not have personal problems that cannot be shared.

In Rajshahi most of the respondents do not have personal problems that cannot be shared (60.50%) and 30.50% of the respondents have personal problem that cannot be shared.

4.41 Reason behind not sharing personal problem



	Feeling Shy	Problem is not serious	It should not be shared	Afraid of sharing	Lack of person
Dhaka	32%	19%	27%	7%	17%
Chittagong	45.76%	20.34%	16.95%	6.78%	11.02%
Rajshahi	24.19%	17.74%	27.42%	12.90%	20.97%

Figure 4.41: Reason behind not sharing personal problem

In Dhaka among 100 respondents having personal problem 32% of the respondents feel shy to share personal problems, 27% of the respondents think personal problem should not be shared, 19% of the respondents think that problem is not serious, 17% of the respondents have lack of persons to share personal problems and 7% of the respondents afraid of sharing personal problems.

In Chittagong among 118 respondents having personal problem 45.76% of the respondents feel shy to share personal problems, 20.34% of the respondents think that problem is not serious, 16.95% of the respondents think that personal problem should not be shared, 11.02% of the respondents have lack of persons to share personal problems and 6.78% of the respondents afraid of sharing personal problems.

In Rajshahi among 61 respondents having personal problem 27.42% of the respondents think that personal problem should not be shared, 24.19% of the respondents feel shy to share personal problems, 20.97% of the respondents have lack of persons to share personal problems, 17.74% of the respondents think that problem is not serious and 12.90% of the respondents afraid of sharing personal problems.

4.42 Fighting with fellow students

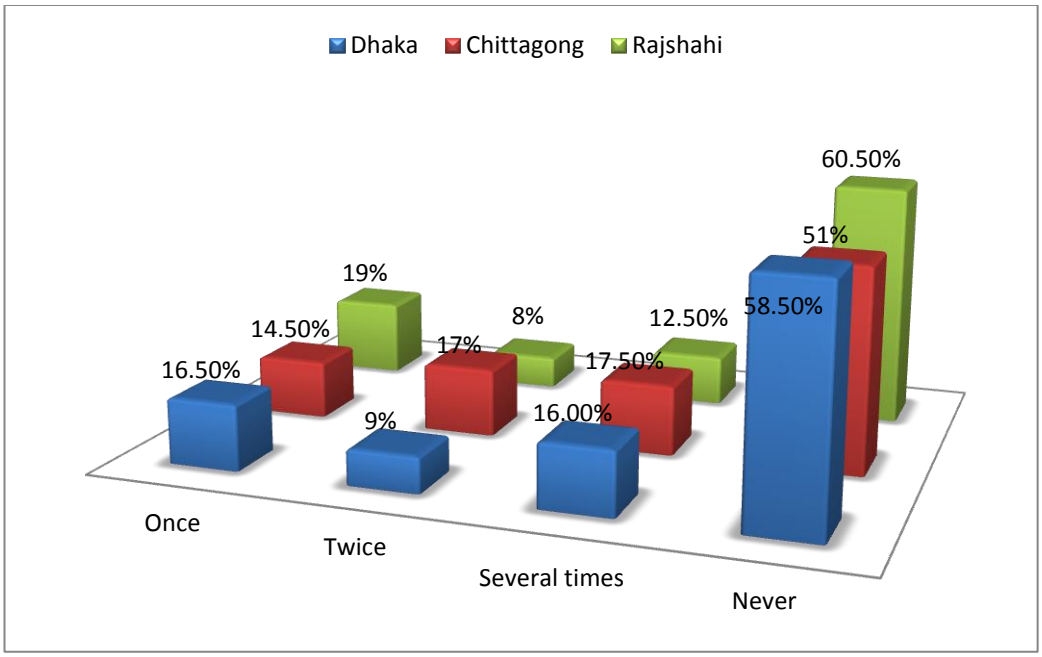


Figure 4.42: Fighting with fellow students

In Dhaka most of the respondents never fight with fellow students (58.50%), 16.50% of the respondents fought once with fellow students, 16.00% of the respondents fought several times with fellow students and 9% of the respondents fought twice with fellow students.

In Chittagong almost half of the respondents never fight with fellow students (51%), 17.50% of the respondents fought several times with fellow students, 17.00% of the respondents fought twice with fellow students and 14.50% of the respondents fought once with fellow students.

In Rajshahi most of the respondents never fight with fellow students (60.50%), 19% of the respondents fought once with fellow students, 12.50% of the respondents fought several times with fellow students and 8% of the respondents fought twice with fellow students.

4.43 Reason behind fighting

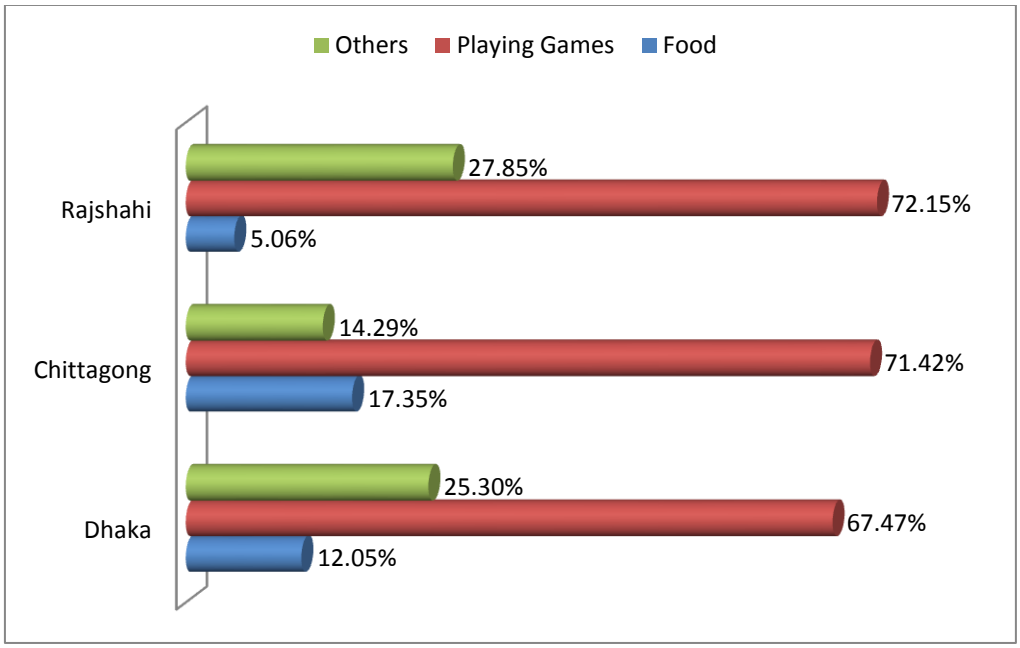


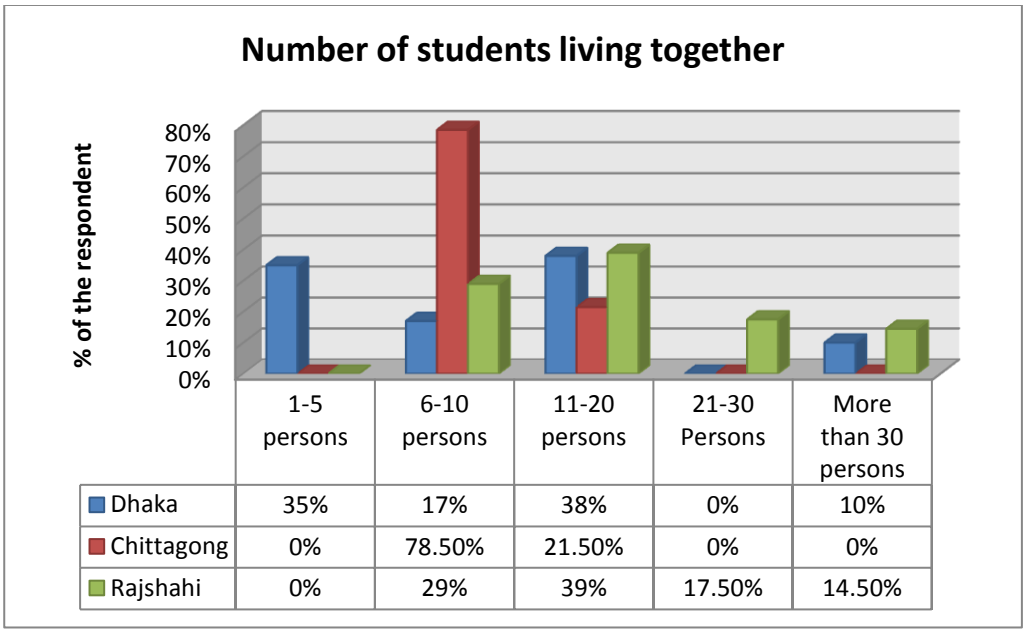
Figure 4.43: Reason behind fighting

In Dhaka among 83 students having fighting with fellow students most of the respondents fought while playing games (67.47%), 25.30% of the respondents fought for other reasons, and 12.05% of the respondents fought while having food.

In Chittagong among 98 students having fighting with fellow students most of the respondents fought while playing games (71.42%), 17.35% of the respondents fought while having food for other reasons, and 14.29% of the respondents fought while other reasons.

In Rajshahi among 79 students having fighting with fellow students most of the respondents fought while playing games (72.15%), 27.85% of the respondents fought for other reasons, and 5.06% of the respondents fought while having food.

4.44 Number of students living together



	1-5 persons	6-10 persons	11-20 persons	21-30 Persons	More than 30 persons
Dhaka	35%	17%	38%	0%	10%
Chittagong	0%	78.50%	21.50%	0%	0%
Rajshahi	0%	29%	39%	17.50%	14.50%

Figure 4.44: Number of students living together

In Dhaka among 200 respondents 38% live in a room with 11-20 persons, 35% live in a room with 1-5 persons, 17% live in a room with 6-10 persons and 10% live in a room with more than 30 persons.

In Chittagong among 200 respondents 78.50% live in a room with 6-10 persons and 21.50% live in a room with 11-20 persons.

In Dhaka among 200 respondents 39% live in a room with 11-20 persons, 29% live in a room with 6-10 persons and 17.50% live in a room with 21-30 persons and 14.50% live in a room with more than 30 persons.

4.45 Sleeping facilities

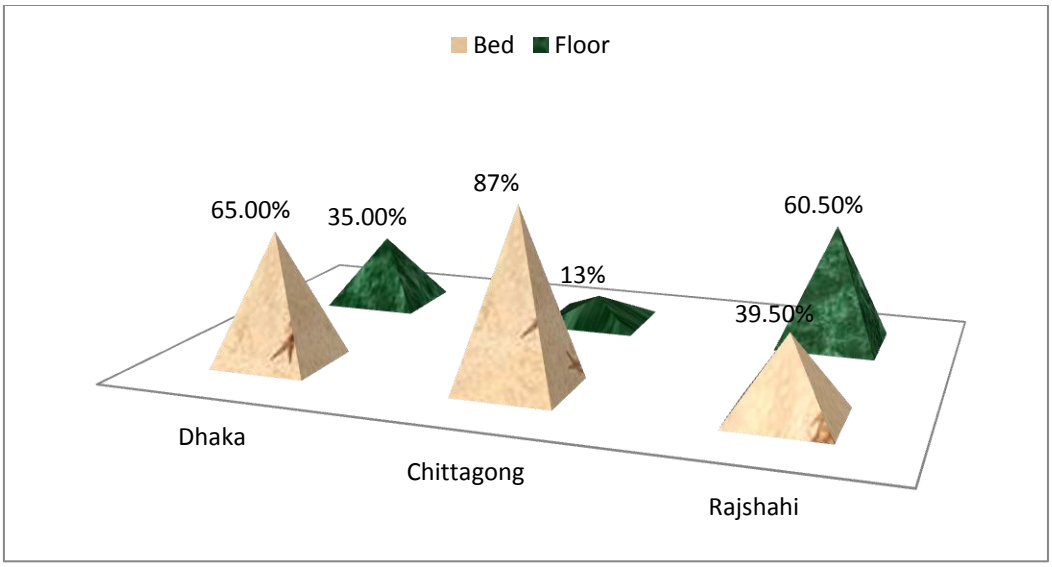


Figure 4.45: Sleeping facilities

In Dhaka most of the respondents sleep on the bed (65.00%) and 35.00% of the respondents sleep on the floor.

In Chittagong most of the respondents sleep on the bed (87%) and 13% of the respondents sleep on the floor.

In Rajshahi most of the respondents sleep on the floor (60.50%) and 39.50% of the respondents sleep on the bed.

4.46 Bed sharing with fellow students

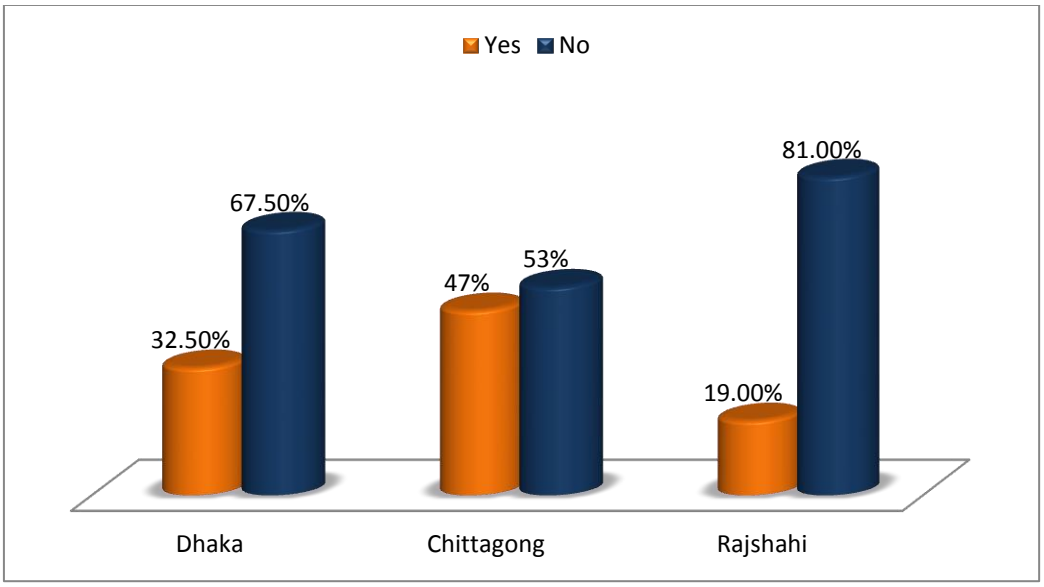


Figure 4.46: Bed sharing with fellow students

In Dhaka most of the respondents do not share bed with each other (67.50%) and 32.50% of the respondents share bed with each other.

In Chittagong almost half of the respondents do not share with each other (53%) and 47% of the respondents share bed with each other.

In Rajshahi most of the respondents do not share bed with each other (81.00%) and 19.00% of the respondents share bed with each other.

4.47 Feeling discomfort by sharing accommodation

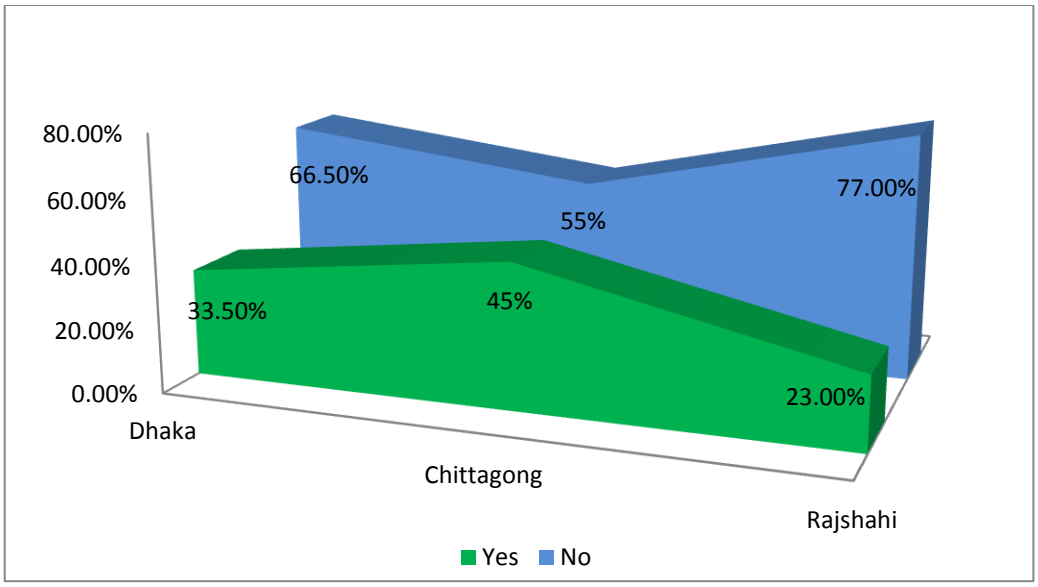


Figure 4.47: Feeling discomfort by sharing accommodation

In Dhaka majority of the respondents do not feel any discomfort by sharing bed with fellow students (66.50%). Rest of the respondents feel discomfort to share bed (33.50%).

In Chittagong majority of the respondents do not feel any discomfort by sharing bed with fellow students (55%). Rest of the respondents feel discomfort to share bed (45%).

In Rajshahi majority of the respondents do not feel any discomfort by sharing bed with fellow students (77%). Rest of the respondents feel discomfort to share bed (23%).

4.48 Self hurting tendency

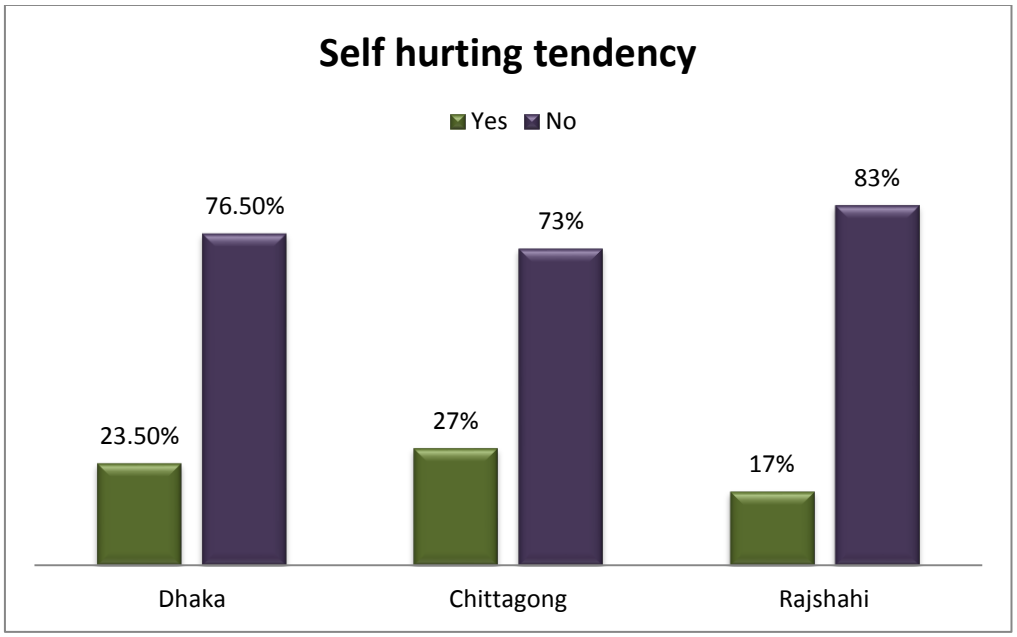


Figure 4.48: Self hurting tendency

In Dhaka majority of the students do not have the tendency to hurt themselves (76.50%) and rest 23.50% respondents have the tendency to hurt themselves.

In Chittagong majority of the students do not have the tendency to hurt themselves (73%) and rest 27% respondents have the tendency to hurt themselves.

In Rajshahi majority of the students do not have the tendency to hurt themselves (83%) and rest 17% respondents have the tendency to hurt themselves.

4.49 Feeling close to the people of the institution

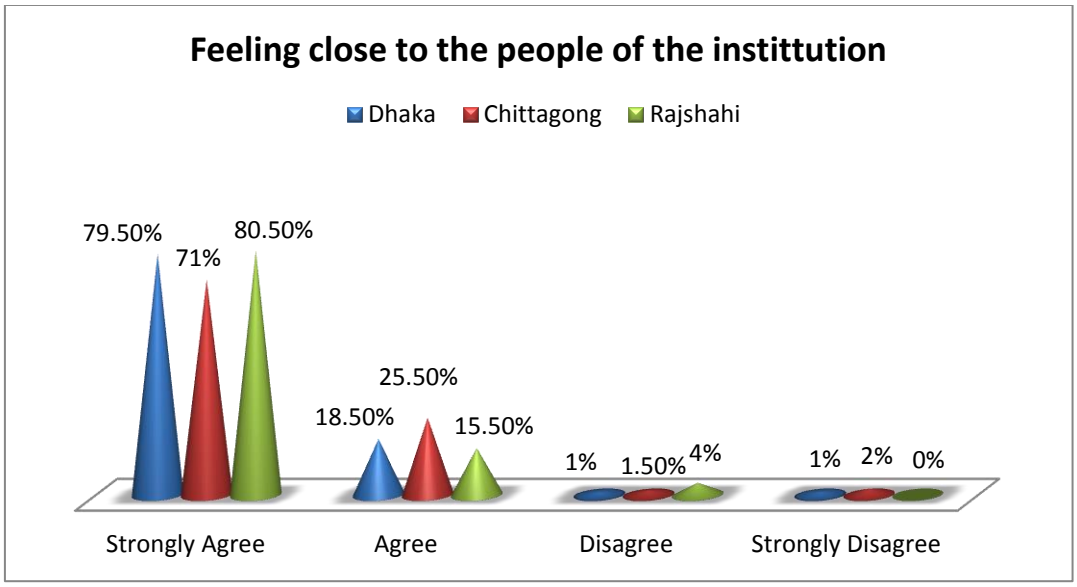


Figure 4.50: Feeling close to the people of the institution

In Dhaka among 200 respondents 98% agree with they feel close to the people of the institution. 2% disagree with this.

In Chittagong among 200 respondents 96.50% agree with they feel close to the people of the institution. 3.50% disagree with this.

In Rajshahi among 200 respondents 96% agree with they feel close to the people of the institution. 4% disagree with this.

4.50 Feeling happy to be in the institution

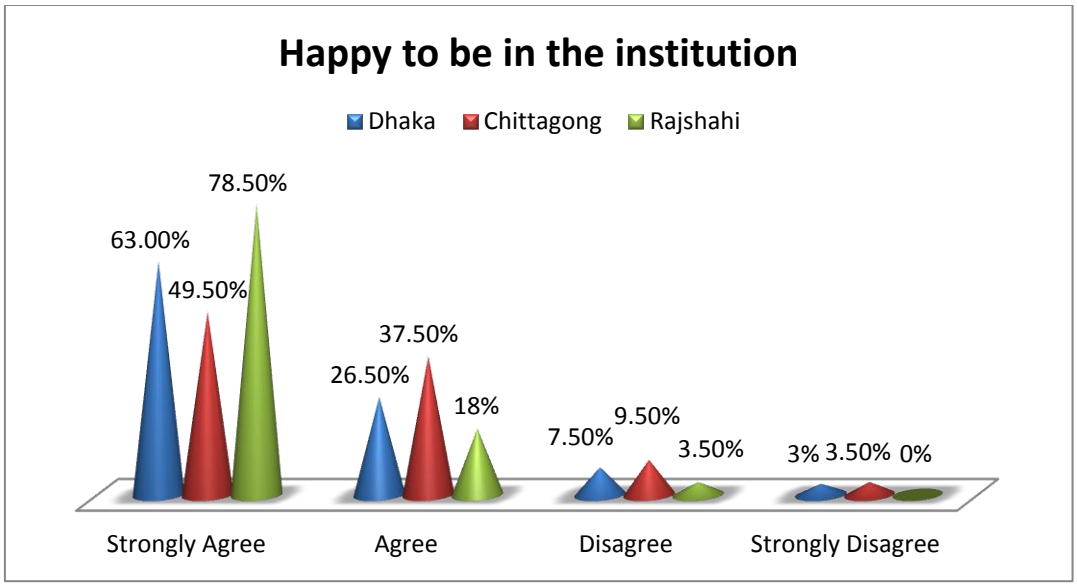


Figure 4.50: Feeling happy to be in the institution

In Dhaka among 200 respondents 89.50% agree with they are happy to be in the institution. 10.50% disagree with this.

In Chittagong among 200 respondents 87% agree with they are happy to be in the institution. 13% disagree with this.

In Rajshahi among 200 respondents 96.50% agree with they are happy to be in the institution. 3.50% disagree with this.

4.51 Senior students treat junior students fairly

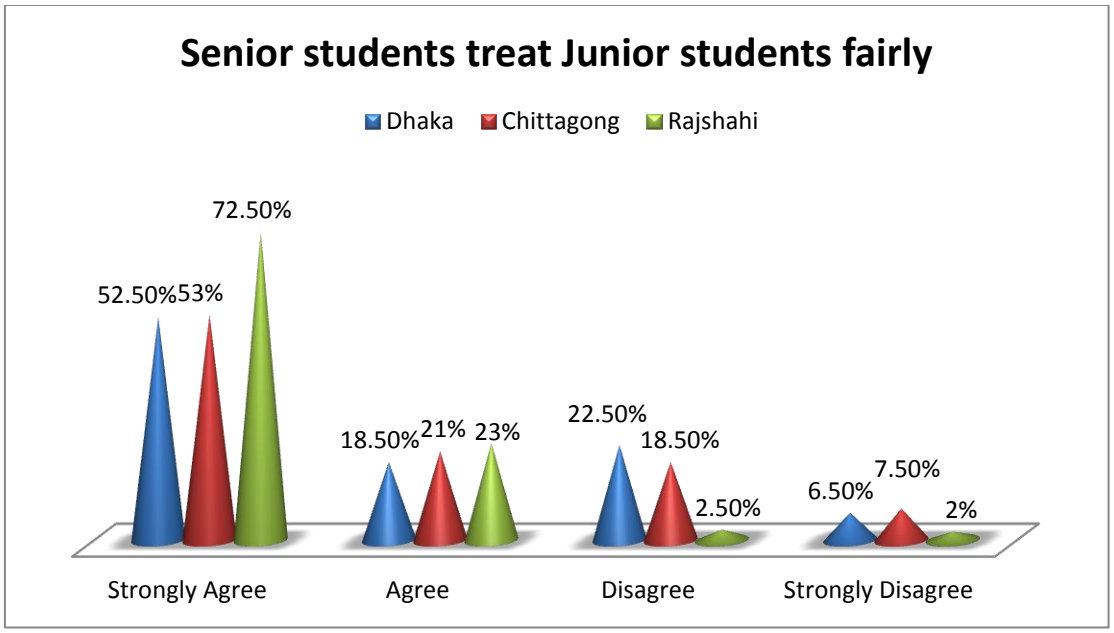


Figure 4.51: Senior students treat junior students fairly

In Dhaka among 200 respondents 71% agree with senior students treat junior students fairly. 29% disagree with this.

In Chittagong among 200 respondents 74% agree with senior students treat junior students fairly. 26% disagree with this.

In Rajshahi among 200 respondents 95.5% agree with senior students treat junior students fairly. 4.5% disagree with this.

4.52 Unfair treatment

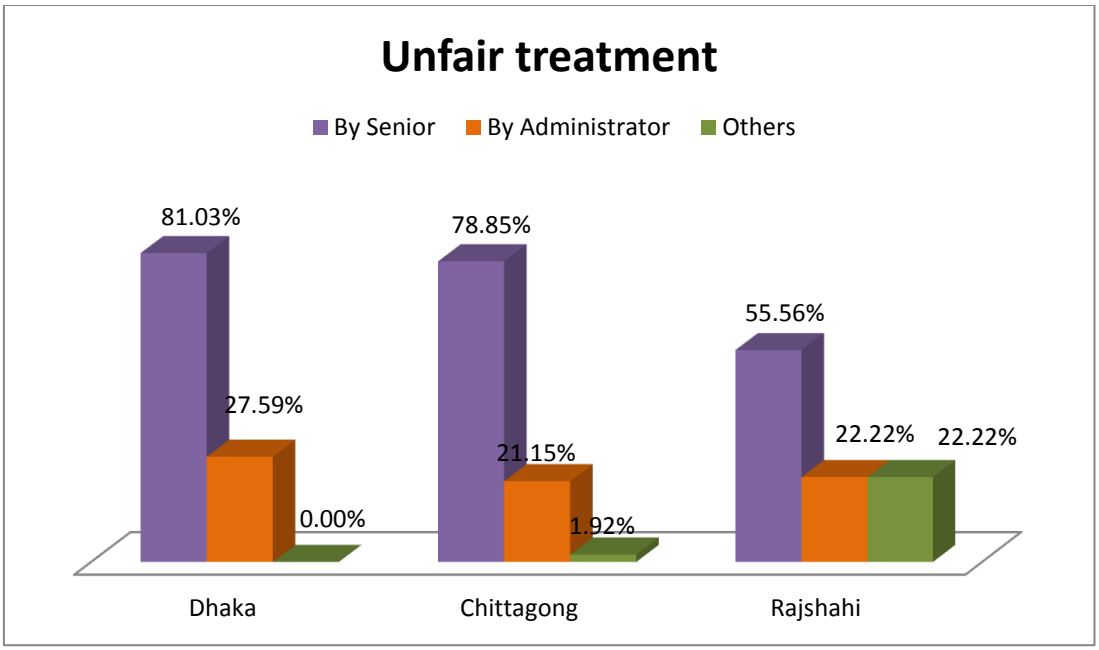


Figure 4.52: Unfair treatment

In Dhaka among 58 respondents facing unfair treatment 81.03% unfairly treated by seniors of the institution and rest 7.59% unfairly treated by administrators of the institution.

In Chittagong among 52 respondents facing unfair treatment 78.85% unfairly treated by seniors of the institution, 15% unfairly treated by administrators of the institution and rest 1.92% unfairly treated by others.

In Rajshahi among 9 respondents facing unfair treatment 55.56% unfairly treated by seniors of the institution, 22.22% unfairly treated by administrators of the institution and rest 22.22% unfairly treated by others.

4.53 Facing harassment in the public place

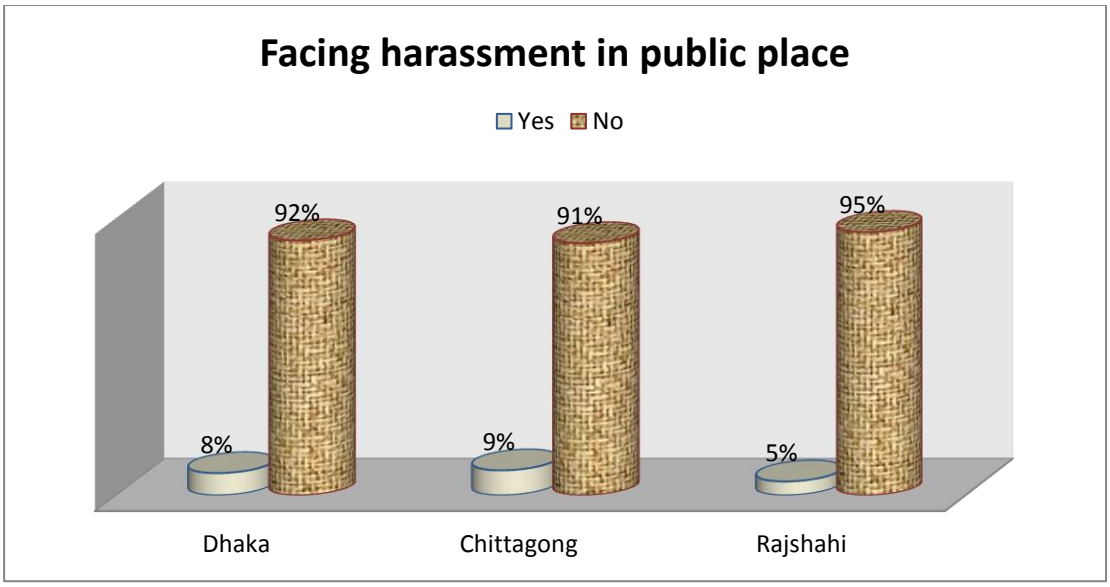


Figure 4.53: Facing harassment in the public place

In Dhaka majority of the respondents do not face harassment in the public place (92%) and a few respondents face harassment in the public place (8%).

In Chittagong majority of the respondents do not face harassment in the public place (91%) and a few respondents face harassment in the public place (9%).

In Rajshahi majority of the respondents do not face harassment in the public place (95%) and a few respondents face harassment in the public place (5%).

Chapter 5

Discussion

Discussion

Madrasa students are one of the largest parts of students in Bangladesh. Most of the madrasa students live in the institution. The study was conducted among 600 madrasa students from three districts Dhaka, Chittagong & Rajshahi. Each district has equal population. Most of the respondents were between 13-18 years old (90% -96%) The objective of the study was to evaluate their general health status, their food habit, common disease pattern, their awareness through basic health and sanitation knowledge.

From this study it was found that majority of the students take heavy meal 3 times per day (69.50% -84.50%). But they had a poor nutritional diet. Though most of them had a habit of taking rice/ bread and vegetables twice per day, their protein intake was very poor which was found from their meat/fish and milk intake tendency. They took meat/fist several times in a week (32.50%) or once per week (23.16%). Majority of the students drink milk occasionally (45%). There was a tendency of meal skipping among the students of Dhaka, Chittagong and Rajshahi (44% - 51.50%). This scenario is very strong when the students become ill (36.60%) and the students do not like the food provided by the institution (29.10%). In Rajshahi a 27.27% students mentioned that they don't get enough time to take food when n Dhaka and Chittagong this percentages are 20.39% and 15.31% respectively. From their food habit it can be assume that their development of growth can be hampered due to their insufficient nutritional diet and meal skipping tendency. There is a high tendency of taking junk food among the students of Dhaka (83.50%), Chittagong (77.50%) and Rajshahi (77.50%) which may cause many kinds of disease specially GI disorders among the students.

Proper sleep is necessary for the health of the students. Without proper sleep their growth will not develop and their mental health will be disturbed. According to National Sleep Foundation teenagers aged 13-18 years old need 8-10 hours of sleep. From our study it was found that most of the students had 8-9 hour of sleep (54.50% - 63%). But a good percentage of students had sleep of less than 6 hours (34.50% - 40%) (National sleep foundation, 2015)

In most of the institution in Chittagong and Rajshahi the source of drinking water was safe as more than 98% students drink tube well water, boiled water and filtered water.

In this study it was found that more than 40% of the students faced sanitation problem. In all three districts less number of toilet and lack of clean toilet were behind the reason for facing sanitation problem. From the study it was found that a good number of students are not conscious about sanitation knowledge. They did not wash hand after using toilet (26.50%) and before taking meal regularly (21.50%). The reason was their unwillingness and unconscious of the importance regarding this situation. They can be a lead to many kinds of skin diseases and GI disorders.

Oral health is very important part of health. For this purpose tooth cleaning is necessary. Without proper tooth cleaning tooth maybe affected my germs and oral health may be hampered. Students of the madrasa were conscious about this thing. Tooth cleaning tendency was very high among the students. More than 95% of the students from Dhaka Chittagong and Rajshahi cleaned their tooth regularly. Most of the students used toothpaste for cleaning their teeth (63.50%).

Physical exercise is very important for the betterment of the health. From the guideline of WHO teenagers should play sport or take physical exercise 60 minutes every day. From this study it was found that in Dhaka most of students did not play games or take physical exercise regularly. But in Chittagong and Rajshahi a good number of students had the opportunity of playing games which is play a vital role in the development of their health. The reason behind students who did not play regularly was not having playground facilities. In Dhaka, Chittagong and Rajshahi 50%, 28.50% and 49.50% respectively students did not get playground facilities (WHO, 2015).

From the study it was found that 81% students from Dhaka, 73.50% students and 77.50% students from Rajshahi suffered from illness during last six months. In Dhaka most of the common diseases were fever, common cold and GI disorder. Among the disease common cold rate was high 37.04%. In Chittagong almost half of the students having diseases had fever (48.98%). In Rajshahi a high percentage of GIT disorder is found as a good number of students did not wash wash hand properly after using toilet and before taking meal.

Most of the students from Dhaka, Chittagong and Rajshahi were used to go doctor when they became ill. But on the other hand a good percentage was also found of taking self-medication. 40.74% students from Dhaka, 34.01% students from

Chittagong and 63.87% students from Rajshahi took self-medication when they become ill. In Most of cases students took self-medication from their teacher's and parents' suggestion. As most of institutions did not have any healthcare professionals the tendency of self-medication was high. In Rajshahi it was found that no institution had healthcare professionals only one institution had an outside doctor. Majority of the students from Dhaka, Chittagong and Rajshahi were found who suffered from chronic diseases. In Dhaka majority of chronic diseases were Jaundice and asthma. In Chiitagong and Rajshahi percentage of having Jaundice is low but having asthma is high. Majority of the students from Dhaka, Chittagong and Rajshahi take allopathic treatment when they become ill(61.33%). But homeopathic treatment is also popular among the students.

Most of the students had knowledge about vaccination. But many of the students were confused about their vaccination history. They had good knowledge about health right and many of them thought that they were deprived of this service. Majority of the students from Dhaka, Chittagong and Rajshahi do not take yearly health checkup.

From the study it was found that most of the students share their problems with their parents and friends. It was also found that more than half of the students had some personal problems that they could not share due to feeling shy, lack of person and they think their problem is not that much serious to be shared. Majority of the students did not have the tendency to fighting with fellow students.

Living condition has many effects on the physical and mental health of the students. In the madrasa most of cases student lived with six to twenty person together which may hamper their sleep, mental health etc. Though most of the students slept in bed many of them had to share bed with fellow students which may cause ease of spreading disease among the students. There were a few students who had self-hurting tendency. In some cases it was found that juniors were treated unfairly by the seniors and administrator of the institution. But it was found that most of the students felt safe in the institution when they became ill, they were happy to be in the institution and they felt close to the people of the institution which is very necessary for the development of their mental health.

Chapter 6

Conclusion

Conclusion

In a summary it can be told that the life style of the madrasa students has an impact on their disease. Most of students were found to have poor nutritional diet. They had junk food habit. They had a poor practice of sanitation and hygiene which was closely related to their disease pattern. Most of the students were not conscious of their health. Students had practice of self-medication instead of seeking professional help. Most of institution did not have any healthcare professional. Students were deprived of proper accommodation facilities. Most of the institutions did not provide playground facilities and any scope of entertainment for the students which are very important for the development mental health for the students. Most of the students were found to be happy in their institution. Students are the future of nature. In Bangladesh a large number of students are from madrasa. So, Madrasa authority and government should work together to develop the current situation by providing necessary facilities and awareness programs.

Chapter 7

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