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Knowledge and attitude gap toward ear, nose, and throat foreign bodies in children among parents and teachers in Federal Capital Territory

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ABSTRACT

Objectives: Ear, nose, and throat (ENT) foreign bodies (FBs) are common Otorhinolaryngological emergencies, especially among children. This study aims to assess the knowledge and attitude gap towards ENT FBs in children among parents and teachers, with a view to advocating public enlightenment on the dangers of ENT FBs in children. This study aims to assess the knowledge and attitude gap toward ENT FBs in children among parents and teachers with a view to advocating public enlightenment on the dangers of ENT FBs.

Material and Methods: This was a cross-sectional descriptive prospective study. A multistage sampling method was used to enroll participants among the six Area Councils in the Federal Capital Territory. Participants were among parents and guardians whose children attended those schools. The instrument for data collection was a pre-tested, standardized, and semi-structured questionnaire.

Results: Of the 270 questionnaires issued, there were only 240 responses, which consisted of 29 parents and 211 teachers. Among the teachers, there were 128 females (60.7%) and 83 males (39.3%) M: F 1:1.5. Majority of them were 30–39 years 102 (51.2%). Most of the parents were between 30 and 39 years 14 (48.3%).

Conclusion: Awareness creation among the parents and teachers is fundamental to bridge the attitude gap in our society.

Keywords: Foreign bodies, Children, Parents and teachers

INTRODUCTION

Ear, nose, and throat (ENT) foreign bodies (FBs) are common Otorhinolaryngological emergencies.[1,2] They account for 11–30% of Otorhinolaryngological emergencies.[3] FBs in the ENT could be living and non-living. Among the non-living, they could be organic and inorganic.[1,3,4] The effect of FBs on children varies, ranging from mere discomfort to a life-threatening emergency.[2,5,6] ENT FBs are more common among children under five years of age[5,6] for various reasons. This includes curiosity, imitation, boredom, the need to explore orifices, mental retardation, and fun-seeking.[2,3,5] Otorhinolaryngologists, Pediatricians, and Emergency and Primary Care Physicians are the Specialists that usually attend to these patients.[1,3,4]

Ibekwe *et al*. conducted a retrospective study among 202 pediatric patients who presented to the emergency with various injuries; 181 had FB injuries, with a male-to-female ratio of 1.1:1. Most of these patients were three years old. The most common site was the nasal cavity (48.62%), followed by the ear with the insertion of beads (28.17%). They found up to 23 patients required a tracheostomy as part of their treatment.[7] Adedeji *et al*. found a prevalence of 5.7% among all the ENT cases seen in adults and children, and most of the cases were found in children under five years of age. In addition, most of the FBs were found in the ear. It was, however, noted that the most frequent foreign material seen were seeds.[8]

In other regions, authors have published findings similar to the ones in Nigeria.[9] In a hospital-based study by Awad and El-Taher,[3] they found a prevalence of 30%, most common among boys within the age of 6 years. The majority had FBs in the aerodigestive tract, followed by aural, nasal, and airway FB inhalation. Mukherjee *et al*. also found a male preponderance with a mean age of about five years in their study. Most of the foreign material was found in the nose. They also found that poor educational background, low socioeconomic status, and being a child of a housewife were significantly associated with FB insertion in children.[5] Loperfido *et al*. also found a male preponderance and a mean age of 5.5 years in their study, consisting of a sample size of 1623 children. The foreign materials were most common in the ear, followed by the nose, pharynx, mouth, and airway.[10] A study done in Malaysia by Chai *et al*. with 1084 children also had similar findings. The most common site was the ear, followed by the nose, pharynx, and esophagus.[6]

All sorts of FBs can be found in children. These range from food particles such as nuts, seeds, food bolus, bones, and sweets to non-food particles such as beads, batteries, small toy parts, biro parts, and any small material that they can lay their hands on.[1,3,5,7-10]

The symptoms depend on the site where the foreign materials are found. An FB might present in the ear with no symptoms, pain, signs of inflammation, or hearing impairment.[8] In the throat or food passage, it may present irritability, drooling of saliva, sudden onset of cough, and choking spells.[3,8] FBs in the nose may present with unilateral foul-smelling rhinorrhea, epistaxis, and nasal blockage, and it may get dislodged into the esophagus or airway, requiring emergency removal under general anesthesia.[9,10]

Most FBs can be removed in the clinic, as reported by Adedeji *et al*. All FBs in the ear and nose were removed in the clinic without anesthesia. For FB in the throat, only nine out of 25 had to be removed under general anesthesia; the remaining were removed in a clinic by the ENT nurses (85%) and family Physicians (8%).[8] Loperfido *et al*. also has more cases of FBs addressed in the clinic (1049), while few (35) had surgical intervention in the theater.[10] Hira *et al*. reported septal perforation and epistaxis as complications noted after nasal FB removal.[9]

Children spend most of their time at home with their parents or in school with their teachers. Therefore, the first "diagnosis" of FB insertion/ingestion/aspiration is made by either the parent/caregiver or the teacher. Schools are environments where children from different backgrounds come together for learning, play, and social interaction.[11,12] Younger children need close supervision and constant attention. As such, the teacher often assumes multiple roles of teaching, caregiving, and, in some instances, the administration of first aid in medical emergencies.[11-13] In some schools, the number of students may overwhelm the teacher, whose attention is already fixed on imparting knowledge to the students. This may mean that the teacher may be unable to detect that a child has inserted an FB or immediately give the child appropriate attention. Parental attention is also vital in early intervention in cases of ENT FBs in children. Older children may report insertion of FBs, but younger children may only present with signs that may suggest an FB has passed into the ear, nose, or throat.[3]

The knowledge, attitudes, and practices (KAP) of parents and teachers regarding ENT FBs in children are important factors influencing the prevention, diagnosis and treatment of these cases. Parents and teachers are often the first to notice or suspect ENT FBs in children and decide whether to seek medical help or attempt to remove them by themselves. Their KAP may affect the type, location, duration, and complication of ENT FBs in children. Therefore, it is important to study parents' and teachers' KAPs regarding ENT FBs in children, as they are the primary caregivers and educators of this age group. This study aims to assess the level of KAP of parents and teachers. However, there are insufficient studies on the KAP of parents and teachers regarding ENT FBs in children in our environment. Most previous studies have focused on the clinical aspects of ENT FBs, such as their presentation, characteristics, management, and outcomes. Therefore, this study aims to assess the KAP of parents and teachers regarding ENT FBs in children and to identify the factors associated with them.

MATERIAL AND METHODS

This was a cross-sectional descriptive and prospective study conducted among teachers in various schools in the Federal Capital Territory (FCT) and among parents/guardians whose children/wards attend those schools. The instrument for data collection was a pre-tested, standardized, and semi-structured questionnaire. The questionnaire consisted of four sections: Sociodemographic profile of participants, KAP sessions. Before the administration of the questionnaire, consent was obtained from participants.

A multistage sampling method was used to enroll participants. Among the six Area Councils in the FCT, three were randomly selected (stage 1). From each of the selected Area Councils, three wards (a total of nine wards were selected) were randomly selected (stage 2). In each of the selected wards, two schools (1 private and one government) were selected, making a total of 18 selected schools selected (stage 3). In each selected school, ten teachers and five parents were randomly selected to participate in the study (totaling 270 participants). Random sampling was carried out by a process of balloting.

The inclusion criteria were teachers who taught in primary and junior secondary schools within the FCT and parents/guardians whose child/ward attended the schools. Parents/guardians and teachers who did not consent were excluded from the study. Data were analyzed using the Statistical Package for the Social Sciences version 24. Responses of the participants to items on the questionnaire were scored on each point, and summary counts were expressed in percentages. Correct responses were scored one mark, while wrong and non-responses were scored zero. Statistical significance was set at a 95% confidence level and $\alpha = 0.05$.

RESULTS

There were 240 responses (29 parents and 211 teachers) out of the 270 questionnaires.

Teachers' KAP

Among the teachers, there were 128 females (60.7%) and 83 males (39.3%) M: F 1:1.5. Majority of them were 30–39 years 102 (51.2%), followed by 40–49, which were 44 (20.9%), as shown in Table 1.

Table 2 shows the teachers' education level and the category of students being taught. Most teachers (70.6%) have a tertiary level of education and are secondary school teachers.

In terms of teaching experience, most of the teachers have taught for more than ten years (45%). In addition, most teach in privately owned schools in the Gwagwalada area council of Abuja, as shown in Table 3.

Table 1: Age and sex of teachers (*n*=211).

Sex		
Male	83	39.3
Female	128	60.7
Age group (years)		
20–29	35	16.6
30–39	108	51.2
40–49	44	20.9
50–59	22	10.4
≥60	2	0.9

Table 2: Level of education and classes taught.

Level of education		
Secondary	11	5.2
Tertiary	149	70.6
Postgraduate	47	22.3
Others	4	1.9
Category of students you are teaching		
Pre-nursery	17	8.1
Nursery	20	9.5
Primary	62	29.4
Secondary	110	52.1
Others	2	0.9

Table 3: Teaching experience and type of school.

Number of years in practice		
<5	40	19.0
5–9	55	26.0
≥10	95	45.0
Not specified	21	10.0
Area council of practice		
Municipal	25	11.8
Gwagwalada	116	55.0
Kwali	50	23.7
Kuje	18	8.5
Abaji	1	0.5
Bwari	1	0.5
Type of school		
Government-owned	93	44.1
Private owned	107	50.7
Others	11	5.2

KAP

Figure 1 shows teachers' KAPs on ENT FBs. One hundred and six (50.2%) had poor knowledge compared to 49.8% with good knowledge.

However, they showed good attitude (84.4%) and practice (69.2%), with only (15.6%) and (30.8%) showing poor attitudes and poor practice, respectively [Figure 1].

There was no significant association between the sex ($P = 0.932$), age group ($P = 0.062$), level of education ($P = 0.066$), category of students taught ($P = 0.969$), number of years in practice as a teacher ($P = 0.360$), or location among our study population (0.604) [Table 4].

The Chi-square test for association also showed no significant association between the sex ($P = 0.097$), age group ($P = 0.631$), level of education ($P = 0.777$), category of students taught ($P = 0.382$), number of years in practice as a teacher ($P = 0.584$), or location among our study population ($P = 0.231$)

Comparing the sociodemographics of the teachers with their practices, sex ($P = 0.097$), age group ($P = 0.631$), level of

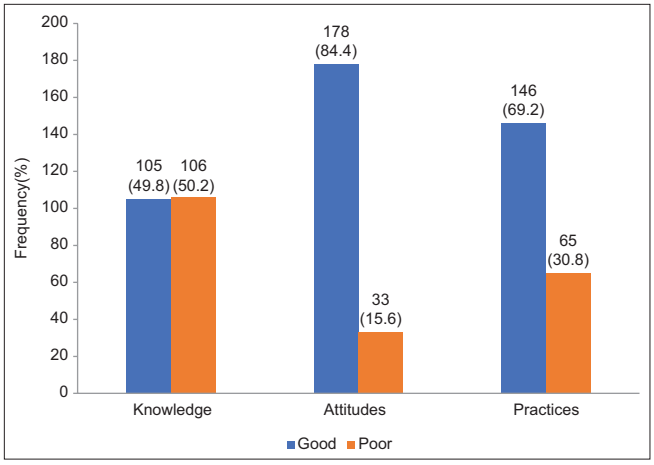

Figure 1: Knowledge attitudes and practices of teachers.

education ($P = 0.777$), category of students taught ($P = 0.382$), number of years in practice as a teacher ($P = 0.584$), or location among our study population ($P = 0.231$) [Table 5].

Parents' KAP

The number of parents who had a valid response was 29 [Table 6].

Most of the parents attained a tertiary level of education 16 (55.2%), and most of them were civil servants 14 (48.3%), who also resided in Gwagwalada area council of the FCT.

Overall, the parents had good knowledge 17 (58.6%), attitude 25 (86.2%), and practice 19 (65.5%) [Table 7].

There was a significant association between the age of the patients and their knowledge of FBs ($P = 0.009$). However, there was no association between sex ($P = 0.354$), educational status ($P = 0.518$), occupation ($P = 0.167$), and area of domicile ($P = 0.467$) [Table 8].

The test for association between sociodemographic profile and the parents' attitudes showed a good association between the area of domicile and the attitude ($P = 0.003$). Still, there was no significant association between age ($P = 0.180$), gender ($P = 0.523$), educational status ($P = 0.914$), and occupation ($P = 0.338$) [Table 9].

There was no significant association between sex ($P = o.633$), age group ($P = 0.303$), education ($P = 0.302$), occupation ($P = 0.736$), and area of domicile ($P = 0.259$) and practices [Table 10].

Table 4: Association between sociodemographic profile of teachers and knowledge.

Variables	Knowledge		χ^2	*P*-value
	Good *n*=105 *n* (%)	Poor *n*=106 *n* (%)		
Sex				
Male	41 (39.0)	42 (39.6)	0.007	0.932
Female	64 (61.0)	64 (60.4)		
Age group (years)				
20–29	13 (12.4)	22 (20.8)	8.983	0.062
30–39	53 (50.5)	55 (51.9)		
40–49	23 (21.9)	21 (19.8)		
50–59	16 (15.2)	6 (5.7)		
≥60	0 (0.0)	2 (1.9)		
Education				
Secondary	3 (2.9)	8 (7.6)	7.193	0.066
Tertiary	71 (67.6)	78 (73.6)		
Postgraduate	30 (28.6)	17 (16.0)		
Others	1 (1.0)	3 (2.8)		
Category of students being taught				
Pre-nursery	8 (7.6)	9 (8.5)	0.549	0.969
Nursery	9 (8.5)	11 (10.4)		
Primary	33 (31.5)	29 (27.4)		
Secondary	54 (51.4)	56 (52.8)		
Others	1 (1.0)	1 (0.9)		
Number of years in practice				
<5	16 (17.0)	24 (25.0)	2.044	0.360
5–9	30 (31.9)	25 (26.0)		
≥10	48 (51.1)	47 (49.0)		
Area council of practice				
Municipal	12 (11.4)	13 (12.3)	3.626	0.604
Gwagwalada	55 (52.4)	61 (57.5)		
Kwali	29 (27.6)	21 (19.9)		
Kuje	9 (8.6)	9 (8.5)		
Abaji	0 (0.0)	1 (0.9)		
Bwari	0 (0.0)	1 (0.9)		
Area council of domicile				
Municipal	15 (14.3)	11 (10.4)	2.400	0.663
Gwagwalada	55 (52.4)	63 (59.5)		
Kwali	25 (23.7)	19 (17.9)		
Kuje	9 (8.6)	12 (11.4)		
Bwari	1 (1.0)	1 (0.9)		
Type of school				
Government-owned	46 (43.8)	47 (44.3)	0.106	0.948
Private owned	54 (51.4)	53 (50.0)		
Others	5 (4.8)	6 (5.7)		

χ^2Chi-square test statistic

DISCUSSION

Children tend to insert foreign materials in the ear, nose, or throat with consequences that may be mild or severe or could even lead to death. Most of the children involved are school age who may encounter these objects in their homes or at school. This makes the role of the parent or teacher vital in preventing, treating, and rehabilitating these children. Most of the respondents (teachers and parents) were in their 4th decade and of the female gender. Furthermore, in both groups, most respondents had a tertiary education and resided in the Gwagwalada area council. Most of the teachers had been

Table 5: Association between the socio-demographic profile of teachers and practices.

Variables	Practices		χ^2	*P*-value
	Good *n*=146 *n* (%)	Poor *n*=65 *n* (%)		
Sex				
Male	52 (35.6)	31 (47.7)	2.749	0.097
Female	94 (64.4)	34 (52.3)		
Age group (years)				
20–29	27 (18.5)	8 (12.3)	2.575	0.631
30–39	71 (48.6)	37 (56.9)		
40–49	31 (21.2)	13 (20.0)		
50–59	15 (10.3)	7 (10.8)		
≥60	2 (1.4)	0 (0.0)		
Education				
Secondary	8 (5.5)	3 (4.6)	1.101	0.777
Tertiary	105 (71.9)	44 (67.7)		
Postgraduate	31 (21.2)	16 (24.6)		
Others	2 (1.4)	2 (3.1)		
Category of students being taught				
Pre-nursery	13 (8.9)	4 (6.2)	4.185	0.382
Nursery	16 (11.0)	4 (6.2)		
Primary	46 (31.5)	16 (24.6)		
Secondary	70 (47.9)	40 (61.5)		
Others	1 (0.7)	1 (1.5)		
Number of years in practice	*n*=132	*n*=58		
<5	30 (22.8)	10 (17.2)	1.076	0.584
5–9	39 (29.5)	16 (27.6)		
≥10	63 (47.7)	32 (55.2)		
Area council of practice				
Municipal	14 (9.6)	11 (16.9)	6.867	0.231
Gwagwalada	86 (58.9)	30 (46.2)		
Kwali	30 (20.5)	20 (30.8)		
Kuje	14 (9.6)	4 (6.2)		
Abaji	1 (0.7)	0 (0.0)		
Bwari	1 (0.7)	0 (0.0)		
Area council of domicile				
Municipal	14 (9.6)	12 (18.5)	7.144	0.128
Gwagwalada	86 (58.9)	32 (49.2)		
Kwali	27 (18.5)	17 (26.2)		
Kuje	17 (11.6)	4 (6.2)		
Bwari	2 (1.4)	0 (0.0)		
Type of school				
Government-owned	61 (41.8)	32 (49.2)	8.254	0.016*
Private owned	81 (55.5)	26 (40.0)		
Others	4 (2.7)	7 (10.8)		

*Significant at 95%, χ^2Chi-square test statistic

Table 6: Age and sex of the parents.

Sex		
Male	6	20.7
Female	23	79.3
Age group (years)		
20–29	3	10.3
30–39	14	48.3
40–49	7	24.1
50–59	5	17.2
≥60	3	10.3

Table 7: Sociodemographics of parents.

Level of education		
Secondary	1	3.4
Tertiary	16	55.2
Postgraduate	11	37.9
Others	1	3.4
Parent's occupation		
Civil servant	14	48.3
Public servant	6	20.7
Business	5	17.2
Home care	4	13.8
Area council of domicile		
Municipal	2	6.9
Gwagwalada	21	72.4
Kwali	2	6.9
Kuje	4	13.8
Bwari	2	6.9

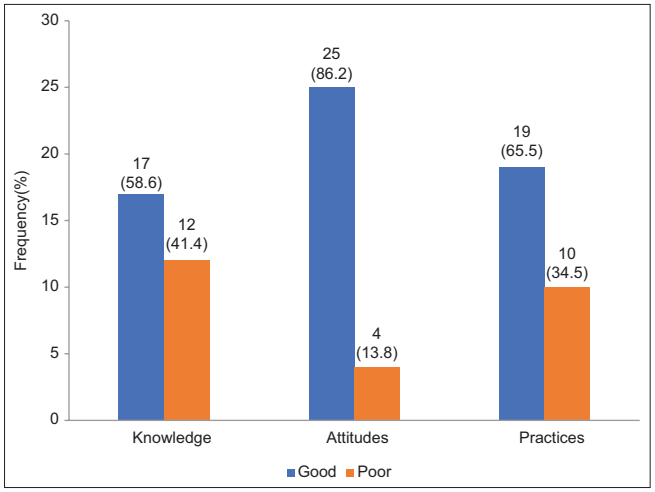

Figure 2: Knowledge attitude and practices of parents.

teaching for over ten years. For the parents, the majority were civil servants. These show the similarity between the subsets of parents and teachers chosen for this study.

The participant's knowledge, attitude, and practice were similar, as shown in Figures 1 and 2. They mostly showed good knowledge about FBs, had good attitudes, and demonstrated good practices toward managing a child who had inserted an FB in the ear. This finding is in contrast with findings by other authors.[12] Educating caregivers/parents, teachers, and the general public goes a long way in disaster prevention and management in ENT FB care.[11] People

Table 8: Association between sociodemographic profile of parents and knowledge.

Variables	Knowledge		χ^2	*P*-value
	Good *n*=17 *n* (%)	Poor *n*=12 *n* (%)		
Sex				
Male	5 (29.4)	1 (8.3)	1.905	0.354[f]
Female	12 (70.6)	11 (91.7)		
Age group (years)				
20–29	0 (0.0)	3 (25.0)	11.568	0.009*
30–39	6 (35.3)	8 (66.7)		
40–49	7 (41.2)	0 (0.0)		
50–59	4 (23.5)	1 (8.3)		
Education				
Secondary	0 (0.0)	1 (8.3)	2.274	0.518
Tertiary	9 (52.9)	7 (58.3)		
Postgraduate	7 (41.2)	4 (33.3)		
Others	1 (5.9)	0 (0.0)		
Occupation				
Home care	1 (5.9)	3 (25.0)	5.060	0.167
Civil servant	11 (64.7)	3 (25.0)		
Public servant	3 (17.6)	3 (25.0)		
Business	2 (11.8)	3 (25.0)		
Area council of domicile				
Municipal	1 (5.9)	1 (8.3)	2.547	0.467
Gwagwalada	14 (82.4)	7 (58.3)		
Kwali	1 (5.9)	1 (8.3)		
Kuje	1 (5.9)	3 (25.0)		

*Significant at 95%, χ^2Chisquare test statistic, [f]Fisher's exact test

Table 9: Association between sociodemographic profile of parents and attitudes.

Variables	Attitudes		χ^2	*P*-value
	Good *n*=25 *n* (%)	Poor *n*=4 *n* (%)		
Sex				
Male	4 (16.0)	2 (50.0)	2.429	0.180[f]
Female	21 (84.0)	2 (50.0)		
Age group (years)				
20–29	2 (8.0)	1 (25.0)	2.248	0.523
30–39	12 (48.0)	2 (50.0)		
40–49	7 (28.0)	0 (0.0)		
50–59	4 (16.0)	1 (25.0)		
Education				
Secondary	1 (4.0)	0 (0.0)	0.521	0.914
Tertiary	14 (56.0)	2 (50.0)		
Postgraduate	9 (36.0)	2 (50.0)		
Others	1 (4.0)	0 (0.0)		
Occupation				
Home care	4 (16.0)	0 (0.0)	3.370	0.338
Civil servant	12 (48.0)	2 (50.0)		
Public servant	4 (16.0)	2 (50.0)		
Business	5 (20.0)	0 (0.0)		
Area council of domicile				
Municipal	0 (0.0)	2 (50.0)	13.782	0.003*
Gwagwalada	19 (76.0)	2 (50.0)		
Kwali	2 (8.0)	0 (0.0)		
Kuje	4 (16.0)	0 (0.0)		

*Significant at 95%, χ^2Chi-square test statistic, [f]Fisher's exact test

with foreknowledge of how to act in an emergency, like FB insertion, are likely to make the best decisions. Rao *et al.* published a study in India to evaluate the preparedness of schoolteachers to respond to health emergencies. About 92% of the teachers admitted to not being confident in dealing with emergency health situations.[12] A study in the United States on school nurses to ascertain their preparedness to handle potentially life-threatening emergencies revealed that the majority of the schools did not have an identified personnel who makes important medical decisions on behalf of the students.[13]

Among the teachers, there was a weak association between the gender of the teacher, the age group, level of education, classes being taught, area of domicile of the school, and whether the school was privately owned or government-owned. This shows that the teachers have similar basic ideas of what an FB is and how they can handle it, irrespective of their sociodemographic differences. This may be due to the knowledge they have from their basic training at the colleges of education.

Among the parents, there was a significant positive association between the age group of the parents and their knowledge about FB. This connotes that the older the parent, the more likely they know FBs in ENT. This can be attributed to parental experience. Furthermore, there was a significant association between the area of parents' domicile and their attitudes. The parents responded from three area councils. The one with the largest population (Gwagwalada) also has the highest number of civil servants with tertiary education. These factors make them more likely to make better decisions in caring for their children as it is likely they have come across such during their school days or have friends or neighbors who are doctors or have some knowledge about FB prevention in ENT. There was a weak association between the other sociodemographic attributes of the parents and the teachers. The number of parents recruited for the study may account for this as they are insufficient to make proper inferences on the association. A study with a larger sample size may need to be conducted to make an appropriate inference.

Table 10: Association between sociodemographic profile of parents and practices.

Variables	Practices		χ^2	*P*-value
	Good *n*=19 *n* (%)	Poor *n*=10 *n* (%)		
Sex				
Male	3 (15.8)	3 (30.0)	0.806	0.633[f]
Female	16 (84.2)	7 (70.0)		
Age group (years)				
20–29	3 (15.8)	0 (0.0)	3.644	0.303
30–39	7 (36.8)	7 (70.0)		
40–49	5 (26.3)	2 (20.0)		
50–59	4 (21.1)	1 (10.0)		
Education				
Secondary	0 (0.0)	1 (10.0)	3.649	0.302
Tertiary	12 (63.2)	4 (40.0)		
Postgraduate	6 (31.6)	5 (50.0)		
Others	1 (5.2)	0 (0.0)		
Occupation				
Home care	3 (15.8)	1 (10.0)	1.272	0.736
Civil servant	9 (47.3)	5 (50.0)		
Public servant	3 (15.8)	3 (30.0)		
Business	4 (21.1)	1 (10.0)		
Area council of domicile				
Municipal	1 (5.2)	1 (10.0)	4.023	0.259
Gwagwalada	12 (63.2)	9 (90.0)		
Kwali	2 (10.5)	0 (0.0)		
Kuje	4 (21.1)	0 (0.0)		

χ^2Chi-square test statistic, [f]Fisher's exact test

CONCLUSION

The KAPs of ENT FBs among teachers and parents were generally good. However, in practice, it is observed that children with FB insertions usually present late; thus, there seems to be a disconnect between the knowledge, attitudes, and practices of teachers and parents and what is observed in the hospital. Perhaps, this may be because the study was conducted in the FCT, where the literacy level is higher than in other parts of Nigeria. Hence, there is a need for further studies to be conducted in rural areas where literacy levels are lower, and there is a need for public enlightenment on the dangers of ENT FBs in those areas. This public enlightenment could also target the few teachers and parents with poor KAPs.

Ethical approval

The research/study complied with the Helsinki Declaration of 1964.

Declaration of patient consent

Patient's consent is not required as patients identity is not disclosed or compromised.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

Use of artificial intelligence (AI)-assisted technology for manuscript preparation

The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript, and no images were manipulated using AI.

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