

**ASSESSMENT OF
COMMUNICATION
STRATEGIES FOR
PROMOTING PERSONAL
HYGIENE PRACTICES
AMONG SELECT
ADOLESCENT STUDENTS IN
JOS SOUTH LGA PLATEAU
STATE.**

**Plateau State University Journal of
Communication Studies (PLASUJOCS)
2026, Vol. 3(1)**

**©2026 by the Department of Mass
Communication, Plateau State University
Bokkos, Nigeria.**

<http://journals.plasu.edu.ng/index.php/pjcs>

FWANGKES, KENRET

Abstract

Over the years, the communication of personal hygiene among adolescent students in secondary schools has not been given due attention. It has been noted that personal hygiene deficiency diseases have been found to be a serious public health problem in a developing country like Nigeria. Adolescent students are particularly vulnerable to the consequences of lack of basic personal hygiene. Therefore, this study is focused at assessing communication of personal hygiene practice among adolescents in selected secondary schools of Jos South, Plateau State. The study deployed the Health Belief model which was developed exclusively to explain health-related behaviours in the early 1950's by a group of social psychologists in the U.S public services. The study adopted a mixed research approach by using Questionnaire, Focused Group Discussion and Key informant interview. Findings from the study revealed that there is low understanding of personal hygiene among students in Educare Chosen High School and Government secondary school Hwolshe. It also revealed that the major channels of communicating personal hygiene to the students in both schools are Physical and Health Education and the Assembly ground, which have proven to be less effective in influencing personal hygiene practice among adolescents in the selected schools. More so, financial constraint was discovered to be a factor militating against good personal hygiene practice. Therefore, in order to mitigate these challenges, the study recommends that the use of participatory health talk forum that is gender sensitive could help in facilitating the adoption of good personal hygiene behaviour amongst students. The study concludes that behavioural change communication can only be effective if participatory approaches are deployed.

Keywords: Personal Hygiene, Adolescents, Health Communication, Behavioural Change, Participatory communication.

Background

The concept of personal hygiene is concerned with taking good care of the entire human body through the adoption of conscious healthy behaviors such as; hand washing, grooming of nails, keeping neat hair, bathing, and mouth washing. These healthy behaviors reduce the vulnerability of the body to bacterial, viral and fungal infections. Personal hygiene is the overall health status of the body and mind, it is the effort made by an individual to keep his/her body and mind performing optimally (Oparah, 2011). Though the concept of personal hygiene is essentially idiosyncratic; it is concerned with an individual's personal commitment to his/her own social, physical, mental, and emotional wellbeing. It has often been described as that component of physical health that is primarily concerned with the means and procedure by which the human body is kept at its best performance (Windy, 2002). This implies that, it is a conscious effort made by an individual to ensure that good hygiene is practiced and maintained for healthy living; hence, knowledge of personal hygiene is demonstrated in an individual's ability to effectively practice healthy habits (Onuzulike, 2002).

Personal hygiene, as a behavioral phenomenon requires deliberate communication and enculturation of healthy

habits because diseases such as diarrhea, malaria, skin infections, body odor, mouth odor, and typhoid are remotely and directly caused by lack of good hygiene. Practicing good personal hygiene has a lot of significance and value; it serves as a tool for disease prevention and health promotion of individuals, families and communities. It can also reduce threats of communicable diseases that are preventable, thereby improving the overall health of an individual. In 2018, Nigeria's Water, Sanitation and Hygiene (WASH) sector was declared to be in a state of emergency by the Government. In 2019, a combination of inadequate infrastructure, a lack of required human capital, poor investment, and a deficient enabling regulatory environment amongst other challenges meant that approximately 60 million Nigerians were living without access to basic drinking water. 80 million people had no access to improved sanitation facilities, while 167 million couldn't access basic handwashing facilities. In rural areas, 39% of households lack access to at least basic water supply, while only half have access to improved sanitation and almost a third (29%) practice open defecation a fraction that has marginally changed since 1990. (World bank report 2021).

Certain consequences may develop as a result of poor hygiene, ranging from social

problems to potentially serious diseases. According to Chris (2015), one of the most prominent consequences of poor hygiene is body odor, and this occurs through the interaction of bacteria and sweat produced by the apocrine glands. He further asserts that, as bacteria thrive in unwashed sweat over time; their by-products produce the smell commonly associated with body odor. Body odor may also be as a result of poor bathroom habit, when the body is not properly washed. Bad breath is another easily recognizable consequence of poor hygiene and usually develops from the irregular brushing of teeth. People who are exposed to these unhealthy lifestyles, whose health are jeopardized by poor hygiene are also vulnerable to diseases that usually could have been prevented.

Personal hygiene deficiency diseases have been found to cause serious public health problems and children are often the victims of such lapses. These have been attributed to inadequate knowledge of personal hygiene and its practices. Overtime, hygiene education, as it is usually communicated, has had disappointing results and the reason is because several reviews of the effectiveness of health education point to very disappointing results. Burgers, Boot and Van (1988) reveal that "one reason for this poor performance is because health education is often tacked on as an

afterthought in health programs; it has low priority and has little claim on management time and programme resources". Another reason is the top-down approach of communication that fails to respond to what people know, do and want Loevinsohn, (1990). Therefore, the realization of this necessity in order to achieve healthy hygiene behavior, to a large extent, depends on effective communication.

Communication for Development (C4D) as adopted by the United Nations (UN), stresses the need to support two-way communication systems that allow communities to speak out, express their aspirations and concerns as well as participate in the decisions that relate to their development. It could therefore, be argued that effective communication channels and methods are essential in achieving any kind of development. This means that, there is an urgent need to incorporate a communication strategy that is more flexible and participatory.

Statement of the Research Problem

Personal hygiene-related diseases remain a significant public health concern in developing countries such as Nigeria, with adolescents in secondary schools among the most vulnerable groups. Poor personal hygiene practices expose students to preventable conditions including diarrhoea,

typhoid, skin infections, oral diseases, and body odour, all of which negatively affect their health, school attendance, academic performance, and overall well-being. Although these consequences are widely acknowledged, poor hygiene practices continue to persist among school-age adolescents, suggesting that existing approaches to hygiene communication have not produced the desired behavioural outcomes.

In many Nigerian secondary schools, personal hygiene is promoted primarily through routine inspections, assembly announcements, and Physical and Health Education lessons that emphasize compliance with school regulations such as clean uniforms, trimmed nails, neat hair, and oral cleanliness. While these measures encourage temporary conformity, they often rely on one-way communication and enforcement rather than sustained behavioural change. Consequently, students may comply with hygiene requirements without developing a clear understanding of the health implications of poor hygiene or the motivation to adopt hygienic practices voluntarily in their daily lives.

Despite increasing recognition that behaviour change requires participatory and audience-centred communication strategies, limited attention has been given to assessing

the effectiveness of the communication approaches currently used to promote personal hygiene among adolescent students in secondary schools, particularly within the context of Jos South Local Government Area of Plateau State. Existing studies have focused predominantly on students' knowledge and hygiene practices, with comparatively little emphasis on evaluating the communication strategies through which hygiene information is delivered and how these influence behavioural outcomes.

This gap raises important questions about whether the communication channels currently adopted by schools are sufficiently engaging, participatory, and effective in promoting sustainable personal hygiene practices among adolescents. It is against this background that this study assesses the communication strategies used to promote personal hygiene among adolescent students in selected secondary schools in Jos South Local Government Area, Plateau State, with a view to identifying communication approaches that can more effectively facilitate positive and sustained hygiene behaviour.

Methodology

This study adopted a convergent parallel mixed-methods research design, combining quantitative and qualitative approaches to

obtain a comprehensive understanding of the communication strategies used to promote personal hygiene among adolescent students in selected secondary schools in Jos South Local Government Area of Plateau State. The mixed-methods approach was considered appropriate because the study does not only sought to quantify students' knowledge, perceptions, and exposure to hygiene communication but also to explore the experiences, opinions, and perspectives regarding the effectiveness of existing communication strategies.

The quantitative component involved the administration of questionnaires to students to generate measurable data on their awareness, foundations of hygiene information, communication channels, and hygiene practices. The qualitative component comprised Focus Group Discussions (FGDs) with students and Key Informant Interviews (KIIs) with school principals, Physical and Health Education teachers, health prefects, and recipients of the neatest student award. These qualitative methods provided deeper insights into the strengths, weaknesses, and practical realities of the communication approaches used within the schools.

Both quantitative and qualitative data were collected during the same phase of the study, analysed separately using appropriate

analytical techniques, and integrated into the findings. This enabled the qualitative evidence to explain, validate, and enrich the quantitative results, thereby providing strong assessment of communication strategies for promoting personal hygiene among adolescent students.

Study Area

This study focuses on the communication aspect of personal hygiene practices among adolescent students in selected secondary schools in Jos South LGA of Plateau State, an area affected by hygiene-related diseases due to poor water and sanitation. The research examines students from SS1–SS3 (ages 10–18) in Educare Chosen High School (private) and Government Secondary School Hwolshe (public), selected for their popularity and to ensure balanced data for comparing communication styles and students' attitudes toward personal hygiene, within the 2017/2018 academic session.

Sample Size and Sampling Technique

This study adopts a combination of the clusters and the systemic random sampling techniques in selecting respondents for the study. In the first stage, school students are clustered into groups. That is, SS1, SS2 and SS3, respectively. The second stage involves clustering each group into blocks.

This gave 3 blocks namely: SS1 block, SS2 block and SS3 block. Thus, the estimated numbers of students in each clustered group (blocks) from each school are as follows:

Class	Educare Chosen High School	Government Secondary School
SSS-1	70	100
SS-2	64	100
SS3	58	50
TOTAL	192	250

Source: *Educare chosen high School and Government Secondary School*

Record, 2017.

Hence; in determining the sample size of the given population of four hundred and forty-two (442), the statistical formula used is Yamane formula. According to Yamane (1967), sample size can be determined by the following formula:

$$n = \frac{N}{1 + N(e)^2}$$

$$1 + N(e)^2$$

Where: N = Total Population

E = Level of precision or error limit = 5% or 0.05 n = Sample size

Therefore:

$$N = \frac{442}{1 + 442(0.05)^2}$$

$$1 + 442(0.05)^2 = 442$$

$$1 + 442 \times 0.0025 = 442$$

$$2.105 n = 209.97$$

Therefore; the total sample size population for the two schools under study is 209. This implies that the researcher employed a random distribution of the sum of two hundred and nine copies of questionnaires to the respondents in both schools.

Methods of Data Collection

Due to the nature of this study, the researcher used Questionnaire, Focus Group Discussion (FGD) and Key Informant Interview (KII) as instruments for data collection. The study employed the FGD method by forming a group of six (6) discussants from each of the schools

under study. The discussants were two students randomly selected from each class (SS1-SS3), making up a total of (12) persons. A total of 4 FGDs were conducted in the course of field work. A total of seven (7) KII's were underlisted with the following respondents, Principals, Physical and Health Education (PHE) teachers of both Health Prefects of both schools, and neatest student award recipients under study.

Method of Data Analysis

In this study, the information gotten from the field were analyzed using the framework analysis which states that analysis will be done in line with responses that are in tune with the aim of the research and discarding other information that are not related to the aim of the topic under study. For the data generated from the quantitative tool, the Statistical Package for Social Sciences (SPSS); version 20 was used to represent data in percentages, graphs, frequencies and bars upon which presentation and analysis was made. The descriptive thematic method was applied to transcribe the qualitative data and back up findings from the qualitative data.

Ethical consideration

Before data collection, an information sheet was provided for the participants with details about

INDICES	SA (Strongly Agree)	A (Agree)	U (Undeci ded)	D (Disagree)	SD (Strongl y disagre e)
There are benefits in keeping good personal Hygiene	66 (75.9)	21 (24.1)	-	-	-
	67 (59.9)	33 (29.5)		9 (8.0)	3 (2.7)
There are consequences and health implications when we fail to wash the hands, groom the nails, keep clean hair, brush the teeth and take our bath	65 (74.7)	20 (23.0)		1 (1.1)	1 (1.1)
	51 (45.5)	31 (27.7)	5 (4.5)	14 (12.5)	11 (9.8)
	72 (82.8)	15 (17.2)			
Mouth/body odour and skin diseases can be caused by poor personal hygiene practice	79 (70.5)	27 (24.1)		3 (2.7)	3 (2.7)
Poor hygiene practice can affect students' learning in school	55 (63.2)	28 (32.2)	1 (1.1)	3 (3.4)	-
	52 (46.4)	30 (26.8)	2 (1.8)	21 (18.8)	6 (5.4)

the research. Informed consent was obtained from all study participants. The principles of research ethics which include respect for person, beneficence,

nonmaleficence, and justice were ensured in

ensure the study complied with the national

EDUCARE

GSS HWOLSHE

INDICES	SCORE	RATIO	SCORE	RATIO
Health talk forum	311	0.71	411	0.73
Physical and health education	391	0.90	469	0.84
Clubs and societies	348	0.80	365	0.65
General Assembly Ground	337	0.77	439	0.78
Social media platforms	299	0.69	374	0.66
Pictures	328	0.75	340	0.60
Counselling session	299	0.69	340	0.60

this study. Confidentiality of responses was ensured as there was no form of identifier in the data collection instrument. To further

and state guidelines on research involving human participants, ethical clearance was obtained from both school's authorities.

Presentation

of

Data

Students' Awareness on the Issue of Personal Hygiene

Table 2: Respondents understanding of personal hygiene issues

Key: Figures in parenthesis are %. Bold darkened figures represent data from Educare Chosen high school; Slanted light figures represent data from GSS, Hwolshe. Source: Researcher's field survey, 2018

Table 3. Respondents Grading of Various Channels through which Personal Hygiene is communicated in the Selected Schools

Source: Researcher's field survey, 2018 Note: Any number below 0.5 is insignificant

Table 4: Rating on the effectiveness of channels used in communicating personal hygiene

INDICES	EDUCARE		GSS HWOLSHE	
	Score	Ratio	Score	Ratio
Health talk forum	288	0.66	327	0.58
Physical and health education	319	0.73	345	0.62
Clubs and society	299	0.69	332	0.59
General Assembly Ground	281	0.65	374	0.67

Source: Researcher's field survey, 2018 Note: Any score below 0.5 is insignificant.

Table 5: Respondents score on factors militating against personal hygiene practice among students.

FACTORS	EDUCARE HIGH		GSS HWOLSHE	
	SCORE	RATIO	SCORE	RATIO
Lack of resources (Finance) to acquire basic personal hygiene materials	376	0.86	477	0.85
Laziness on the part of the students	374	0.85	490	0.88
Ignorance on dangers associated with poor personal hygiene practice	340	0.78	486	0.87
Poor supervision of students by the teachers / parents	349	0.80	462	0.83
Poor facilities / Environment	330	0.75	441	0.79

4

Source: Researcher's field survey, 2018**Table 6: Response on ways that could facilitate proper personal hygiene practice among students.**

INDICES	EDUCARE SCORE	HIGH RATIO	GSS SCORE	HWOLSHE RATIO
Strengthen Health talk forum in the school	350	0.80	492	0.87
Inclusion of physical and health education in the senior class school curriculum	360	0.83	478	0.85
Strengthen Clubs and Societies	350	0.80	455	0.81
Strengthen Guidance and counselling Unit.	356	0.82	456	0.81
Use of Cultural/Performative media (Drama Club) in addressing issues on personal hygiene	322	0.74	466	0.83
PTA Forum/Platform	259	0.60	318	0.56
Literacy and Debate platform	319	0.72	373	0.66
Periodic award/praise to the neatest students	366	0.84	397	0.70
Heavy penalty meted on dirty students	333	0.77	427	0.76
Billboards or signposts installed in the strategic places within the school premises on personal hygiene matters	317	0.73	502	0.89

Source: Researcher's field survey, 2018**Discussion of Findings**

In exploring the students' levels of awareness on the issues of personal hygiene in both schools, the findings construed that students from both schools are aware of personal hygiene because it is been taught in

their schools, and they are aware of its importance and significance as demonstrated from their responses on the questionnaire, which covered benefits and consequences such as hand washing, grooming of nails, keeping neat hair, oral

hygiene, bathing, as well as issues like mouth odor, body odour, skin diseases and the effect of poor hygiene on learning. Their responses show that most of them strongly agree that poor hygiene practice has positive and negative consequences, although a low percentage of respondents are unaware. Further probing revealed that students admitted mouth odor, body odor, skin infections and diarrhea as outcomes of poor hygiene behavior, while a greater percentage agreed that poor hygiene can affect learning through absenteeism and reduced academic performance. On perception of bathing, 55% opined that girls should bathe more than once a day while 45% stated both genders should, with FGD discussions attributing this to menstruation and house chores. However, practices such as nail chewing, poor hand washing habits and improper care of hygiene kits reveal a low level of understanding, although students of Educare Chosen High School demonstrated more knowledge than those in GSS Hwolshe.

This inference implies that students are not completely ignorant of personal hygiene, as it is communicated in both schools, but only little knowledge is demonstrated, exposing a low level of understanding of the niceties of personal hygiene. Poor hygiene practice provides an ideal environment for diseases

to thrive and has negative health and social implications such as isolation, low self-esteem, anxiety and depression, while good hygiene promotes better participation and academic excellence, indicating the need to address this knowledge gap.

Table 3 shows that Physical and Health Education is the most used communication channel in both schools, as affirmed by principals, although it is limited to junior secondary level. Respondents highlighted limitations of this channel, noting that students often see it as just another subject and fail to translate it into real-life practice, aligning with views that conventional education methods emphasize academic knowledge without practical application. Health talks and seminars are also used, though described by students as infrequent, non-exclusive and sometimes boring, particularly in GSS Hwolshe where such forums are limited. While both schools are deliberate in communicating hygiene, these approaches are largely brief, theoretical and insufficient for sustainable behavior change, as they do not adequately incorporate life skills or participatory learning.

The findings further show that one-way teaching and lecture-based approaches overlook interaction needed for developing

practical skills, whereas participatory methods such as peer learning, games and group interactions can enhance knowledge, attitudes and practices. Approaches like the Child-to-Child method and life skills-based hygiene education emphasize active participation, practical engagement and linking school learning to real-life situations, thereby improving outcomes.

General assembly inspections were also identified as a method of enforcing hygiene, but students reported feeling coerced rather than motivated, leading to temporary compliance. Practices such as punishment for long nails, including forcing students to chew their nails, were reported and noted to have harmful health implications. These findings suggest that enforcement-based strategies are ineffective for long-term behavior change and highlight the need for improved communication approaches.

The study also revealed several factors militating against the adoption of personal hygiene, including lack of basic sanitary items, poor facilities, and socio-economic conditions. Demographic data showed that many households have 5–8 members, with parents largely being civil servants and traders, while GSS Hwolshe falls within a lower socio-economic class. Issues such as use of reusable menstrual materials without

proper hygiene knowledge, poor inner wear management, and lack of awareness on proper sanitation practices further expose gaps in knowledge and resources.

The findings align with the Health Belief Model, showing that low perceived susceptibility and severity contribute to poor hygiene practices, while perceived barriers such as lack of facilities and resources hinder behavior change. Past health crises like Ebola and COVID-19 temporarily improved hygiene practices due to perceived threat, but such behaviors were not sustained, indicating that awareness alone is insufficient without motivation and enabling environments. UNICEF (1999) also emphasized that hygiene promotion requires not just awareness but effective strategies that influence behavior through understanding of existing beliefs and practices. Poor facilities were particularly evident in GSS Hwolshe, where there is inadequate water supply and sanitation infrastructure, unlike Educare Chosen High School which has better facilities. Parental nonchalance in providing hygiene materials also contributes to poor practices. These barriers highlight that effective communication alone cannot ensure good hygiene practice without supportive conditions.

Table 6, outlines strategies that could motivate adoption of personal hygiene, including participatory health forums, extension of Physical and Health Education to senior classes, guidance and counselling, drama and cultural media, PTA involvement, and provision of facilities. Incentives such as awards for neatness can encourage positive behavior, while posters and visual communication materials placed strategically within the school can reinforce hygiene messages. Although punishment may influence some students, it remains less effective compared to participatory and motivational approaches. Overall, the findings emphasize that sustainable hygiene practice among adolescent students requires a combination of effective communication, participatory strategies, supportive environments and access to necessary resources.

Conclusion

The study concludes that the communication channels used by both schools are weak and less effective in promoting personal hygiene, as Physical and Health Education is limited to junior classes where students often take lessons lightly and struggle to apply them in real life, leading to low awareness and understanding of hygiene practices. Financial constraints, lack of basic

resources, and socio-economic differences especially among students in GSS Hwolshe further hinder good hygiene practice, while factors such as laziness, ignorance, poor supervision, and nonchalant parental attitudes also contribute, even where resources are available. Therefore, there is a need to review and strengthen existing communication approaches by making them more participatory and gender sensitive to improve students' knowledge, motivation, and adoption of proper hygiene practices.

References

- Ahmadu, B. U., Rimamchika, M., Ibrahim, A., Nnanubumon, A. A., Andrew, G., & Emmanuel, P. (2013). State of personal hygiene among primary school children: Community-based cohort study. *Sudan Journal of Paediatrics*, 13(1), 38–42.
- Burgers, L., Boot, M., & Van Wijk, C. (1988). *Hygiene education in water supply and sanitation programmes*. IRC International Water and Sanitation Centre.
- Emelumadu, O., Ajator, C., Nwazor, O., & Aduba, C. (2023). *Knowledge, attitude and practice of personal hygiene among secondary school students in Anaocha Local Government Area, Anambra State, Nigeria*.

- Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health behavior and health education: Theory, research, and practice* (3rd ed.). Jossey-Bass.
- Janz, N. K., & Becker, M. H. (1984). The Health Belief Model: A decade later. *Health Education Quarterly*, 11(1), 1–47.
- Jegede, E. (2014). *Behavior change communication (BCC)*. Centre of Excellence on Development Communication, Ahmadu Bello University.
- Loevinsohn, B. P. (1990). Health education interventions in developing countries: A methodological review of published articles. *International Journal of Epidemiology*, 19(4), 788–794.
- National Cancer Institute. (2003). *Theory at a glance: A guide for health promotion practice*. U.S. Department of Health and Human Services.
- Oluwafemi, T. (2017). *Knowledge and practice of personal hygiene among secondary school students in Ibadan, Nigeria*.
- Rosenstock, I. M. (1974). Historical origins of the Health Belief Model. *Health Education Monographs*, 2(4), 328–335.
- Schiavo, R. (2007). *Health communication: From theory to practice*. Jossey-Bass.
- Snel, M., Ganguly, S., & Shordt, K. (2002). *School sanitation and hygiene education*. IRC International Water and Sanitation Centre.
- UNICEF. (1999). *Hygiene promotion manual: Towards better programming*. United Nations Children's Fund.
- UNICEF. (2012). *Communication strategy on water, sanitation and hygiene for diarrhoea and cholera prevention, Liberia*. United Nations Children's Fund.
- van Wijk, C., & Murre, T. (1980). *Motivating better hygiene behaviour: Importance for public health mechanisms of change*. IRC International Water and Sanitation Centre.
- World Bank. (2021). *Ensuring water, sanitation and hygiene for all: Nigeria*. World Bank.
- World Health Organization. (2009). *Skills for health: Skills-based health education including life skills*. World Health Organization.