

Health Status and its Impact on Primary and Secondary Education in Bangladesh: A Study on Jamalpur District

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RESEARCH ARTICLE

Abstract

Education is the prerequisite of all developments of a nation, where primary and secondary education play the most crucial role in contributing to the total literacy rate. In the case of primary and secondary school students, health status has a substantial influence on the comprehensive development of the students, comprising their participation, performance, and progress in educational activities. This study focuses on the health status of primary and secondary school students and its impacts on their education. In this study, a mix of both qualitative and quantitative methodologies has been used to reach the deepest health complications of the students. The study shows that most students lack basic health awareness, which leads to health issues and further affects their educational lives. The destructive impacts of health issues include dropping out of school, reluctance to study, inattentiveness, poor performance in class, anxiety, etc. These existing complications can be sorted out by ensuring the good health and well-being of the students through health check-ups, health care services, and counseling. The mental health of the students can be improved by the motivation and cooperation of the teachers and family members.

Keywords: Education, health status, dropout, performance, healthcare services, motivation

DOI: <http://doi.org/10.52631/jemds.v5i3.367>

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Submitted 6 March 2025

Revised 12 June 2025

Accepted 30 July 2026

Citation

Kabir I., Kabir H., Rani Dey, S., Halder, S., Sweety, T. T., Begum, T., Emon, I. U., Rahman, M. A., Asef, A. I., Islam, M. T. (2026). Health Status and its Impact on Primary and Secondary Education in Bangladesh: A Study on Jamalpur District. *Journal of Education, Management and Development Studies*. 5(3). 1-12. doi: 10.52631/jemds.v5i3.367

1 INTRODUCTION

Today's students are the future of the nation, and receiving primary and secondary education is crucial for their development. There are six basic human needs: food, clothing, shelter, education, healthcare, and security. All these needs are equally important; similarly, education and health are fundamental to leading a healthy and productive life. Without education, individuals may struggle to find the right path in life, while poor health can prevent them from achieving their goals. Therefore, education and health are closely interrelated. The relationship between health and education is well established, and public health literature has extensively documented the correlation between these two dimensions of human capital in both developing and developed

countries (Suhrccke & Nieves, 2011). There can be no meaningful education without good health, and a healthy society without education is equally undesirable. Both families and schools play significant roles in the physical and mental development of students. According to the World Health Organization (WHO), health is defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948). Due to age-related and developmental factors, students at the primary and secondary levels are particularly vulnerable to physical and mental health challenges.

In Bangladesh, approximately 20 million students are enrolled in primary education and more than 14.7 million in secondary and higher secondary education (excluding madrasahs), totaling over 35 million students (Bangladesh Bureau of Educational Information and Statistics (BANBEIS), 2024). It is concerning that the dropout rate is higher at the secondary level than at the primary level. According to the Annual Primary School Statistics (APSS) for 2024, the dropout rate increased to 16.25% in 2024 from 13.15% in 2023 (Directorate of Primary Education (DPE), 2024). Similarly, secondary schools in Bangladesh lost more than one million students over four years, as highlighted in the draft report of Bangladesh Education Statistics 2023 (Kamrujjaman et al., 2024). The educational landscape underwent a significant transformation during the COVID-19 pandemic when schools were abruptly closed to prevent the spread of the virus (Selvaraj et al., 2021). Many students contracted COVID-19, which adversely affected their physical health and left lasting aftereffects.

Consequently, students’ capacities and potential for learning were negatively impacted. Bangladesh experienced severe disruptions to its educational system during the pandemic (Kamrujjaman et al., 2024). According to UNICEF, school closures affected nearly 41 million students (UNICEF, 2021). Furthermore, only 36% of students had access to remote learning opportunities (Kamrujjaman et al., 2024). The pandemic not only caused physical health problems but also hindered students’ mental development through isolation, anxiety, and detachment from normal social activities. Students’ health status is directly linked to school attendance and dropout rates. Their present and future educational outcomes are greatly influenced by their physical and mental well-being. This multifaceted issue encompasses socioeconomic inequality, the digital divide, mental health challenges, changes in learning environments, and inequitable resource distribution (Kamrujjaman et al., 2024).

Therefore, it is essential to analyze the health status of students, particularly at the primary and secondary levels, as these stages form the foundation of education. Secondary school students are especially vulnerable to mental health issues due to the challenges associated with puberty and adolescence. During this period, students often struggle to cope with rapid physical, emotional, and psychological changes. As a developing country, Bangladesh faces significant challenges related to poverty and malnutrition. Many students suffer from inadequate nutrition, poor health knowledge, and insufficient hygiene practices, which negatively affect their overall well-being. Consequently, many students experience illnesses, physical disabilities, and mental health disorders that hinder their academic performance.

In addition, students suffering from various health conditions often struggle to continue their studies or perform effectively in school. Therefore, personal hygiene is essential not only for maintaining cleanliness but also for reducing the prevalence and incidence of communicable diseases (Rahman et al., 2014). In the Bangladeshi context, particularly in rural areas, many parents lack awareness regarding their children’s physical and mental health needs. As a result, limited attention is given to children’s mental well-being, despite the fact that childhood is a highly sensitive developmental stage requiring careful support and guidance. Moreover, childhood is one of the most important stages of human life and significantly influences future outcomes. Primary school-aged children can learn health-promoting behaviors even if they do not fully understand the relationship between behavior and disease prevention (Janz & Becker, 1984). Moreover, schools, as important socializing institutions, play a vital role in developing healthy and responsible citizens (Rahman et al., 2014). If children’s mental development is disrupted during these formative years, it can have long-term negative consequences for both their educational achievements and personal lives. The main objective of this research is to know the current

health status and its impact on primary and secondary school students. Specifically, this study aims to know the socio-economic and demographic conditions of the students in primary and secondary schools in Bangladesh; to find out the present health conditions of the students in primary and secondary levels in Bangladesh; to explore the opportunities and challenges of health services available for the students of primary and secondary schools in Bangladesh; and to bring forward suggestions for overcoming the challenges and developing health status of the students of primary and secondary schools in Bangladesh.

2 METHODOLOGY

This study employed a quantitative research approach to examine the health status of primary and secondary school students and its influence on their educational activities. The quantitative method was deemed appropriate as it allows for the systematic collection, measurement, and analysis of numerical data to identify patterns and relationships between students' health conditions and their educational experiences.

2.1 Respondents of the study

The study was conducted in three purposively selected upazilas of Jamalpur District, Bangladesh: Jamalpur Sadar, Melandaha, and Madarganj. These areas were chosen to provide a broader representation of students from both primary and secondary educational institutions. The target population consisted of students enrolled in selected primary and secondary schools within these upazilas. A total of 85 students participated in the study, representing both educational levels.

2.2 Sampling Technique

The study employed a combination of purposive sampling and convenience sampling. Purposive sampling was used to select participating educational institutions. A total of 20 schools, comprising 10 primary and 10 secondary schools, were deliberately selected from the three selected upazilas of Jamalpur District—Jamalpur Sadar, Melandaha, and Madarganj. These schools were selected because they provided appropriate settings and respondents relevant to the objectives of the study.

After schools were identified, convenience sampling was used to select the student respondents. A total of 85 students were included in the study based on their availability and willingness to participate during the data collection period. This approach allowed the researcher to efficiently gather data from students who were accessible while ensuring that the respondents met the study's inclusion criteria: enrollment in the selected primary and secondary schools. Participation in the survey was voluntary, and informed consent was obtained prior to data collection.

2.3 Research Instrument

Primary data was gathered using a structured questionnaire administered directly to the selected respondents. The questionnaire included items on respondents' demographic characteristics, physical health status, health-related practices, access to healthcare services, and the perceived effects of health conditions on academic performance, school attendance, and participation in educational activities. To ensure clarity and consistency, the questionnaire was designed in simple, understandable language appropriate for respondents' educational levels.

In addition to the primary data, secondary data were obtained from scholarly journals, books, government reports, policy documents, newspaper articles, and other relevant publications. These sources provided theoretical foundations, contextual background, and supporting evidence for the interpretation of the study findings.

2.4 Statistical Treatment of Data

The collected data were systematically coded, organized, tabulated, and analyzed using descriptive statistical techniques. Frequencies and percentages were computed to summarize the respondents' demographic profiles and health-related characteristics. Tables and bar charts were used to present the data clearly and facilitate interpretation of the findings.

Microsoft Excel was utilized for data coding, computation, and graphical presentation, while Microsoft Word was used for organizing and documenting the results. The analysis focused on describing the health status of students and examining its relationship with their educational activities. Throughout the data analysis process, careful measures were taken to ensure the accuracy, consistency, and reliability of the findings.

3 RESULTS

Table 1 presents the demographic profiles of the respondents. The occupation of the respondents' fathers reveals a diverse range of professions. Farmers, Masons, and auto-drivers each represent 11.764% of the respondents' fathers, indicating the presence of a significant agricultural and skilled labor workforce. Teachers make up 8.235%, suggesting a notable educational influence within the respondents' families. Businessmen constitute a considerable percentage, accounting for 17.647%, reflecting a substantial entrepreneurial presence. The "others" category encompasses a diverse range of occupations, accounting for 31.764% of respondents' fathers' occupations. This category could include professionals from various fields, self-employed individuals, or individuals engaged in less commonly reported occupations. A smaller proportion of respondents have fathers working as expatriates, comprising 7.058%. Almost all social, economic, and demographic factors were significant predictors of school progress and performance, and most were more strongly related to the outcome than the health factors (Fransoo et al., 2008). These socio-economic and demographic characteristics provide a more comprehensive understanding of the respondent group. The age distribution highlights the age range of participants, enabling targeted analysis of specific developmental stages and age-related experiences. The diversity of occupations among respondents' fathers reflects their varied socio-economic backgrounds and may influence respondents' exposure to different environments and opportunities. Overall, these characteristics play a crucial role in shaping the context and lens through which the respondents' experiences and perspectives can be interpreted and understood.

Table 1. Socio-Economic and Demographic characteristics

Age of respondents	Level of Percentage
0 to 5 years	3.529%
6 to 10 years	35.30%
11 to 15 years	54.117%
16 to 20 years	7.05%
Sex of Respondents	Number of respondents
Male	40%
Female	60%
Occupation of Respondent's Father	Level of percentage
Farmer	11.764%
Mason	11.764%
Auto-Driver	11.764%
Expatriate	7.058%
Teacher	8.235%
Businessmen	17.647%
Others	31.764%

Table 2 provides insights into water consumption, food habits, weight, height, knowledge of blood groups, and exercise patterns of the respondents, which can indicate their overall health. The data shows that a majority of the respondents (60%) consume less than one liter of water, which may suggest inadequate hydration. Food habits vary, with 40% of respondents having a diet consisting of rice, vegetables, fish, eggs, and fruits, indicating a balanced diet, while a significant portion (22.352%) consume a diet rich in fish and meat.

Table 2. Water consumption, food habits, weight, height, sleeping hours, and knowledge about blood groups and exercise patterns of the respondents indicated their health conditions

Water consumption	Level of Percentage
Less one liter	60%
Two liters	34.117%
Three liters	5.882%
Daily food of respondents	Level of percentage
Rich, pulses, vegetable	21.176%
Rich, fish, and meat	22.352%
Rice, vegetables, fish, egg	40%
Rice, vegetables, fish, meat, milk, and fruits	16.470%
Weight of respondents	Level of percentage
15-20	11.764%
21-30	16.470%
31-40	18.823%
41- 50	23.529%
51-60	17.674%
Height of respondent	Level of percentage
3 to 4	17.647%
4 to 5	37.647%
5 to 6	28.235%
Do not know	16.470%
Blood group of respondents	Level of percentage
A+	23.529%
B+	37.64%
O+	12.94%
AB+	7.058%
Do not know	16.4708%
Daily exercise of the respondent	Level of percentage
0 to 5 years	0%
6 to 15 years	70.58%
16 to 20 years	29.42%

Considering weight, the data shows that the highest percentage of respondents (23.529%) falls within the 41 to 50 kg range, followed by 18.823% in the 31 to 40 kg range. In terms of height, the majority of respondents (37.647%) fall within the 4 to 5 feet range, while 28.235% fall within the 5 to 6 feet range. Notably, a significant proportion (16.470%) is unsure about their height.

Regarding the knowledge of blood groups, the most commonly known blood types among the respondents are B+ (37.64%) and A+ (23.529%). A smaller percentage of respondents know their blood type as O+ (12.94%) or AB+ (7.058%), while a considerable proportion (16.470%) is uncertain about their blood group.

In terms of exercise, the data shows that a majority of the respondents (70.58%) in the age range of 5 to 15 years engage in daily exercise, which indicates a relatively active lifestyle. However, a significant proportion (29.42%) in the age range of 16 to 20 years engage in less exercise.

Table 3. Health Education and Health Care Services of Respondents

Health Campaign at School	Percentage level of insufficiency
Primary level	100%
Secondary level	100%
Health counseling center in the local area	Level of percentage
Yes	0%
No	100%
Medical / Financial help from the union or Upazila clinic	Level of percentage
Yes	83.33%
No	16.67%
Health Checkup Service	Level of percentage
Hospital	86.67%
Home	0%
Clinic	13.33%
School	0%

Table 3 provides information on the health education and healthcare services available to the respondents. The data show a lack of health campaigns at both primary and secondary levels of schooling, with 100% indicating insufficient levels. In terms of health counseling centers in the local area, none of the respondents reported their presence, resulting in a 0% availability. However, a significant proportion of respondents (83.33%) reported receiving medical or financial help from the union or Upazila clinic, indicating some support in this aspect. When it comes to health checkup services, the majority (86.67%) reported utilizing hospitals for their checkups, while a smaller percentage (13.33%) relied on clinics. No respondents mentioned receiving health checkups at home or in school.

Table 4. Present Health Condition of the Respondents

Facing a physical problem	Percentage of Physical Problem
Yes	17.647%
No	82.352%
Suffering disease	Percentage of Suffering disease
Yes	76.470%
No	23.529%
Name of diseases	Percentage of the name of the disease
Fever and cough	76.923%
Others	23.076%

Table 4 presents data on the present health condition of the respondents. It shows that 17.647% of respondents reported physical problems, while the majority (82.352%) reported none. Regarding disease, a significant percentage (76.470%) reported currently experiencing a disease, while 23.529% stated they are not currently suffering from any disease. The most commonly reported disease among the respondents is fever and cough, accounting for 76.923%, while the remaining 23.076% reported other types of diseases.

Table 5 provides insights into healthcare services and the existing problems they address. The data indicate that only 10.588% of respondents have had access to school-based health campaigns, while the majority (89.411%) have not. Similarly, a small percentage (2.352%) reported receiving counseling at school, while the majority (97.647%) did not have access to such services. Regarding health checkups, a limited number of respondents (8.235%) had them at hospitals, while the majority (74.117%) opted for home-based checkups. Additionally, 5.882% of respondents visited clinics for their health checkups, while 11.764% utilized school-based checkup services. Regarding medical or financial support, 27.058% of respondents received assistance from community health clinics or Upazila health clinics, while the majority (72.941%) did not have access to such support. Furthermore, 20% of respondents received support from NGOs, while 80% did not. Lastly, 47.058% of respondents had access to healthcare services at school, while 52.941% did not.

Table 5. Service and Existing Problems

Health campaign at school	Percentage of Health Campaign
Yes	10.588%
No	89.411%
Counseling at school	Percentage of counseling
Yes	2.352%
No	97.647%
Health check-up	Percentage of health check-ups
Hospital	8.235%
Home	74.117%
Clinic	5.882%
School	11.764%
Medical or financial support from the community health clinic or the Upazila health clinic	Level of percentage
Yes	27.058%
No	72.941%
NGOs support	Percentage of NGOs support
Yes	20%
No	80%
Health care services at school	Percentage of Health Care
Yes	47.058%
No	52.941%

Table 6 highlights the Impact on the health status of Respondents. In developing countries like India, children from scheduled castes, tribal communities, urban slums, poverty-stricken families, rural areas, and other marginalized groups face a variety of challenges, including impoverishment, malnourishment, scarcity of obtaining high-quality medical care, child marriage, low attendance at school, low learning outcomes, poor sanitation, poor hygiene, and a lack of improved water sources (UNICEF India, n.d.). In this study, it highlights the impacts of the health status of the students on their educational activities. It is noted that students with different health issues have comparatively low attendance, which covers 76.47% of the respondents. On the other hand, students having no or fewer health issues have more attendance in schools, though the percentage is only 23.53%. In the case of class performance, students with good health have

been proven to be better performers. Again, students dealing with health issues often do poorly on the examination, and sometimes they end up dropping out. Moreover, students with good health and well-being are more active in various extracurricular activities, with only 23.53% of students burdened by health complications maintaining a reserved demeanor on school premises and during cultural programs.

Table 6. Impact on Health Status of Respondents

Attendance in School	Level of percentage
Good	23.53%
Bad	76.47%
Performance in Class	Level of percentage
Good	29.41%
Bad	70.58%
Result in Examination	Level of Percentage
Good	17.64%
Bad	82.35%
Participation in extracurricular activities	Level of Percentage
Good	23.53%
Bad	76.47%

Table 7 presents suggestions and recommendations based on the respondents' needs. The data indicate a strong demand for economic support, with 30.588% of respondents expressing this need. Health-related support is also essential, as indicated by 18.823% of respondents. Furthermore, employment opportunities are crucial, with 31.764% of respondents seeking employment support. Education is another important aspect, with 11.764% of respondents highlighting the need for educational support. Finally, there are various other areas where respondents require assistance, as indicated by 7.058% of respondents. These findings emphasize the importance of providing support in these key areas to improve respondents' well-being and quality of life. Efforts should be directed towards addressing economic challenges, improving healthcare access, facilitating employment opportunities, promoting educational support, and addressing other specific needs to meet the requirements of the respondents and enhance their overall well-being.

Table 7. Suggestions and Recommendations

Name of types	Level of percentage
Support is needed from the family	0%
Economic	30.588%
Health	18.823%
Employment	31.764%
Education	11.764%
Others	7.058%

4 DISCUSSION

In this study, the majority of respondents were in the teenage age group, a crucial transitional stage in human development. The age distribution of the students reflects their physical and mental conditions and experiences. Students' health outcomes are often influenced by both school-level and family-level socioeconomic status (Moore & Littlecott, 2015). The diversity of respondents' fathers' occupations also shapes their socioeconomic backgrounds and living standards. Health behaviors are commonly learned from parents through modeling processes

(Voss & Sandercock, 2010). Children from socioeconomically disadvantaged families are more likely to have at least one parent who smokes (Moore & Littlecott, 2015). Furthermore, low-income parents may face barriers in providing opportunities for physical activity and access to healthy foods (Peterson et al., 2002). The findings reveal that most respondents belonged to lower-middle-class and middle-class families. The daily activities of the respondents, including their dietary habits and physical activities, provide a comprehensive picture of their health status and health-related practices. Most respondents were found to follow lifestyles characterized by inadequate, unbalanced diets and unhealthy practices. A growing lack of awareness and negligence regarding physical fitness may expose them to potential health risks and hinder their physical development. Students aged 11–15 were found to be more physically active than those aged 16–20. Vivas et al. (2010) reported that 99.0% of students washed their hands before meals, although only 36.2% used soap.

In contrast, the present study found that most students were unaware of the importance of handwashing before meals, and only a small proportion practiced it regularly. The findings further indicate that most respondents maintained positive familial and social relationships, which contributed to proper socialization and a supportive environment for mental development. However, the lack of health campaigns and counseling services within the locality has deprived many students of access to basic healthcare information and services. Most respondents reported receiving medical treatment from union-level or upazila health facilities during emergencies. School-based health check-ups and community health screening programs were largely absent, resulting in limited access to essential healthcare services. A considerable number of respondents were suffering from various illnesses, particularly fever and the common cold, reflecting their vulnerable physical health status. Aveyard et al. (2004) found that school-level factors explained a higher proportion of the variance in smoking behavior among younger students. Similarly, school authorities in the present study acknowledged the existence of health-related challenges among students, particularly at the primary level. Although many respondents attempted to maintain their physical well-being, fever and cough remained the most common health problems. The emotional consequences of crises can negatively affect students' learning experiences and their ability to cope with uncertainty. Mental health problems often increase disengagement from education and contribute to school dropout (Pareek et al., 2023). Noflidaputri et al. (2025) argued that children who understand the importance of balanced nutrition are more likely to adopt healthy habits and promote awareness within their families and communities. However, the present study found that only 10.58% of respondents had participated in health campaigns organized by their schools. The majority remained outside the coverage of health awareness programs and counseling services. Very few schools reported conducting health campaigns, and these activities were generally organized only once or twice a year.

Furthermore, school health services in Bangladesh remain inadequate, particularly in raising awareness among students and parents regarding health conditions and disease prevention (Aivey et al., 2024). Only a limited number of schools offered medical check-up services, which were often restricted to activities such as blood grouping and the distribution of vitamin A capsules. Such initiatives can contribute to creating a healthy and supportive educational environment and promote positive child development (Aivey et al., 2024). Nearly 80% of respondents reported receiving primary healthcare support at home, while only a small proportion had access to hospital services. Regarding NGO-provided healthcare assistance, only 20% of respondents had benefited from such support, whereas the majority had no access to these services. The overall findings indicate a limited availability of healthcare facilities in the locality, both governmental and non-governmental. Consequently, many students remain deprived of their right to adequate healthcare services.

Moreover, shame and stigma associated with certain illnesses and social conditions often discourage families from seeking healthcare services (Dawkins et al., 2021). Furthermore, the impact of students' health status on their educational activities and academic outcomes. The findings indicate that students experiencing various health problems have comparatively lower school attendance, accounting for 76.47% of the respondents. In contrast, students with fewer or no health-related issues demonstrate better attendance rates, although they constitute only

23.53% of the respondents. This finding suggests that poor health remains a significant barrier to regular school participation. Previous studies have similarly reported that poor physical and mental health conditions contribute to increased absenteeism and reduced engagement in educational activities (Moore & Littlecott, 2015).

The recommendations provided by respondents demonstrate a strong demand for economic support, which is closely linked to their health and educational needs. They also expressed a desire for increased healthcare assistance and educational support from the government. Mia and Inaba (2020) noted that higher educational attainment contributes to better health outcomes and healthier lifestyles, while healthier individuals are more likely to achieve higher levels of education due to increased productivity and greater investment in learning. In addition, a growing concern regarding unemployment was observed among respondents. This heightened anxiety may further threaten their mental health and overall well-being.

5 CONCLUSION AND RECOMMENDATIONS

The present study sought to examine the health status of primary and secondary school students in Bangladesh and to investigate how health-related problems influence their educational outcomes. The findings demonstrate that students' health is a critical determinant of their academic performance, school attendance, learning capacity, and overall educational attainment. Thus, the research question is answered by confirming that poor physical and mental health significantly hinders students' educational progress and undermines the achievement of quality education. The findings reinforce the widely accepted notion that a healthy body supports a healthy mind, emphasizing the inseparable relationship between health and education as two fundamental indicators of human and national development. Health and education are mutually reinforcing. Although the Government of Bangladesh has made substantial efforts to expand access to compulsory primary education, the study indicates that many students continue to experience health-related barriers that negatively affect their educational participation and success. Frequent illness, malnutrition, inadequate hygiene, mental health challenges, and limited access to healthcare contribute to absenteeism, poor academic performance, reduced concentration, diminished self-confidence, and, in some cases, school dropout. The study further reveals that ensuring students' physical and mental well-being is essential for improving educational outcomes and achieving equitable and inclusive quality education. Addressing students' health problems requires coordinated efforts from policymakers, educational institutions, healthcare providers, communities, and parents. Schools should strengthen school health programs by promoting hygiene education, regular health screening, nutrition initiatives, mental health support, and timely referral services. Teachers also have an important role in fostering health awareness, encouraging healthy behaviors, and identifying students who require additional support.

Based on the findings of this study, several recommendations are proposed to improve the health status and educational outcomes of primary and secondary school students. First, schools and relevant authorities should establish and maintain comprehensive health records for students to facilitate regular monitoring and timely intervention. Parents should be encouraged to provide balanced and nutritious diets, promote healthy eating habits, and ensure that children practice proper personal hygiene. Health education should be incorporated into school activities to enhance students' awareness of disease prevention, nutrition, sanitation, and healthy lifestyles. Regular medical check-ups and school-based health screening programs should be organized in collaboration with healthcare providers to identify and address health problems at an early stage. In addition, health awareness campaigns and counseling services should be conducted for both students and parents to encourage preventive healthcare practices and improve physical and mental well-being.

Furthermore, students experiencing physical or mental health problems should have access to timely treatment and professional healthcare services. The availability of qualified healthcare personnel and basic medical facilities in primary and secondary schools should be strengthened to ensure prompt support when needed. Government agencies and educational institutions

should also increase investment in school health programs and improve the accessibility and quality of healthcare services for students. Since economic hardship often limits access to nutritious food and healthcare, targeted financial assistance and social protection measures should be introduced for disadvantaged families. Teachers should receive appropriate training to identify students experiencing emotional distress and create a supportive, inclusive, and stress-free learning environment. Efforts should also be made to reduce excessive academic pressure and unrealistic social expectations while helping students manage anxiety related to academic performance and future employment. Finally, policymakers, education authorities, and public health professionals should adopt an integrated approach by aligning health and education policies, strengthening intersectoral collaboration, and implementing sustainable school health programs that promote students' overall physical, mental, and social well-being. Such comprehensive initiatives will contribute significantly to improving students' health, enhancing educational achievement, and supporting long-term human capital development.

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