Knowledge, Attitude and Practice towards COVID-19 among Private School Teachers of Chitwan, Nepal

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ABSTRACT

Background

The coronavirus disease (COVID-19) pandemic has brought life to a standstill across the world, with nearly 178 countries reporting school closures. As the schools have started reopening slowly, precautions are utmost necessary to prevent the potential spread of COVID-19 in school and community settings.

Objective

To assess knowledge, attitude and practice towards COVID-19 among private school teachers.

Method

A web based cross-sectional analytical study design was undertaken. Currently working private school teachers of Chitwan District were included as a unit of analysis. The snowball sampling technique was employed to identify the eligible participant. Collected data was entered in SPSS version 20 and analyzed using the Chi-square test, Pearson correlation, and binary logistic regression.

Result

Of 344 participants, the majority were male (52.9%), most of the participants were from age group 26-30 years (38.4%). Regarding knowledge, attitude and practice, 57% had good knowledge, 53.2% had favorable attitude and 51.7% had good practice towards COVID-19. Logistic regression analysis demonstrated gender (OR 0.475, 95% CI: 0.256-0.818) and COVID-19 training (OR 25.687, 95% CI 5.354-123.226) were significant with good knowledge.

Conclusion

Knowledge about COVID-19 among private schools teacher was good, attitudes have been mostly favorable, and the practices were mostly adequate. However, good knowledge is not the only factor for better attitude and good practices. It is necessary to implement massive education campaigns, trainings and information via school authorities and health authorities by developing and adopting appropriate guidelines on COVID-19.

KEY WORDS

Attitude-practice, COVID-19, Knowledge, School teacher

INTRODUCTION

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by a novel coronavirus which was first identified in Wuhan City, China.[1] The virus has capacity of human to human transmission through droplets, aerosol, contact etc having incubation period of 14 days and even longer.[2] The main three symptoms of COVID-19 are sudden onset of fever, dry cough, and tiredness.[3] Till 30th Auguest 2020 there were over 2,48,54,140 reported positive cases with 8,38,924 deaths globally and 40,527 confirmed cases 239 deaths in Nepal.[4]

Estimated that 107 countries had implemented national school closures related to COVID-19, affecting 862 million children and young people, roughly half the global student population.[5] School closures are based on evidence and assumptions from influenza outbreaks that they reduce social contacts between students and therefore interrupt the transmission. Precautions are necessary to prevent the potential spread of COVID-19 in school settings.[6,7] In Nepal all schools have been closed since 19 March, forcing over 8 million learners to stay home. In this extraordinary period, the Nepal Teachers' Association (NTA) is cautiously and actively supporting teaching and learning activities, as well as efforts to protect the health and safety of students and educators.[8]

Nowadays, slowly schools are started to reopen, it is important to examine the knowledge, attitude and practice (KAP) towards COVID-19 among teachers to see to what extent there may be room for improvement in the light of current knowledge. Hence, this study aimed to assess the KAP towards COVID-19 among private school teachers.

METHODS

A web based cross-sectional analytical study design was undertaken. Currently working private school teachers of Chitwan District were included in the study as a unit of analysis. Teachers from government school, preschool, plus two and above were excluded from the study. Snowball sampling technique was employed to identify eligible participant. The researchers prepared a list of private schools of Chitwan and their contact numbers. This started with the researchers approaching the teachers in their network. Currently, most of the private schools are running classes via online platforms and have created their own private groups on Viber, WhatsApp, Messenger, or email for communication. They were invited to participate in this survey and further requested to pass the survey participant to the eligible participant(s) in their network. Minimum required sample size was calculated to be 344.

An online administered of questionnaire was preferred due to the pandemic situation. Data collection tool was designed and executed using Google Forms (https://docs.google.com/forms/). Questionnaire was shared on Whatsapp, Messenger, Viber, email, etc. Pretesting of the questionnaire was done in 10% population in similar setting. An online administered of questionnaire was preferred (2020 Aug. 21 to 2020 Aug. 30) following ethical approval from Shree Medical and Technical College (SMTC-IRC: 20200731-6). The questionnaire was shared on Whatsapp, Messenger, Viber, email, etc of the teachers. The online form consisted background information of the study and informed consent at the beginning. The survey questionnaire was developed by the researcher based on extensive literature review, consultation with subject expert, guideline and protocol of CDC, WHO,UNESCO, UNICEF and Ministry of Health and Population, Nepal.[1,7,18,20,21]

The questionnaire consisted 4 parts, part I was related to socio-demographic variables included age, gender, marital status, ethnicity, religion, education, teaching experience, COVID-19 training and sources of information. Part II was related to COVID-19 knowledge which had 24 questions: 1. Meaning (K1), 2. Causes (K2) 3. Mode of transmission (K3-K10) 4. Clinical presentations (K11-K19), 5. Regarding prevention of COVID-19 (K20-K24). These questions were answered on a Yes/No basis with an additional "I don't know" option. A correct answer was assigned 1 point and an incorrect/unknown answer was assigned 0 points. The total knowledge score ranged from 0 to 24, with a higher score denoting a better knowledge of COVID-19. The Cronbach's alpha coefficient of the knowledge questionnaire was 0.837, indicating acceptable internal consistency. Part III was related to attitudes towards COVID-19 which were measured by 5 point likert scale. It contain total 8 items, the total score was 40, cutoff mean score was 28.86, above indicate a favorable attitude and a score equal and below 28.86 indicate an unfavorable attitude. Positive statements were scored from 5 = strongly agree to 1 = strongly disagree, whereas negative statements were scored from 1 = strongly agree to 5 = strongly disagree. Part IV was related to practice, was composed of 10 questions (P1-P10): These questions were answered on a Yes/No basis with an additional "I don't know" option. A correct answer was assigned 1 point and an incorrect/unknown answer was assigned 0 points. Total score of practiced range 0-10, with a higher score denoting a better practice COVID-19.

Submitted questionnaires were extracted from Google Forms and exported to a Microsoft Excel 2016 for cleaning and coding and later imported to Statistical Package for Social Sciences (version-20.0) for statistical analysis. The data were summarized in terms of frequency, percentage, mean and standard deviations (SD). Chi-square tests were applied to determine the association of knowledge (good vs poor), attitude (favorable vs unfavorable), and practice (good vs poor) with socio-demographic characteristics. Overall KAP scores were dichotomized so to find possible determinants of good KAP, a binary logistic regression analysis was applied with 95% CI and p-value less than 0.05 was considered statistically significant. Pearson correlation was applied to determine the correlation between KAP scores.

Table 1. Socio-demographic Variables of the Respondent (n=344)

Characteristics	Frequency (%)
Age in group (years)	
≤ 20-25	67(19.5)
26-30	132(38.4)
31-35	41(11.9)
36-40	21(6.1)
41-45	45(13.1)
46-50	25(7.2)
51 -55	13(3.8)
Mean age 30.66 years	**Min:20, max 55 years**
Gender	
Male	182(52.9)
Female	162(47.1)
Marital Status	
Unmarried	118(34.3)
Married	226(65.7)
Ethnicity	
Dalit	8(2.3)
Janajati	63(18.3)
Madhesi	4(1.2)
Muslim	3(0.9)
Brahmin/Chettri	244 (70.9)
Others	22(6.4)
Religion	
Hinduism	290(84.3)
Buddhism	33(9.6)
Christianity	16(4.6)
Islam	3(0.9)
Others	2(0.6)
Education	
Secondary	57(16.6)
Bachelor	136(39.5)
Master and above	151(43.9)
Experience in years	
< 1-5	95(27.6)
6-10	147(42.7)
11-15	28(8.2)
16-20	49(14.2)
> 20	25(7.3)
COVID-19 Training	
Yes	25(7.3)
No	319(92.7)
Sources of information	
Newspaper	133(38.9)
Internet/ social media	322(94.2)
Television	159(46.5)
Relatives and friend	109(31.9)
Radio/ FM	104(30.4)
Health worker	77(22.5)
Community worker	49(14.3)

Table 2. Correct Response Towards Knowledge of COVID-19 (n=344)

Awareness Questions	Correct Response	Frequency (%)
COVID-19 is a highly infectious disease.	Yes	339(98.5)
Causes of COVID-19	Virus	329(95.6)
Modes of transmission of COVID-19*		
	Air	344(100)
	Eating 'animal meat	235(68.3)
	Eating infected fruits and vegetable	201(58.4)
	Saliva of an infected person	256(74.4)
	Urine and faeces of an infected person	129(37.5)
	Breast milk of an infected person	249(72.4)
	Shaking hands with an infected person	289(84.0)
	Kissing and hugging	249(72.4)
Signs and symptoms of COVID-19		
	Fever	330(95.9)
	Cough	281(81.7)
	Weakness	233(67.7)
	Vomiting	140(40.7)
	Diarrhea	100(29.1)
	Difficulty breathing (shortness of breathing)	270(78.5)
	Severe headache	206(59.9)
	Muscle pain	163(47.4)
	Sore throat	237(68.9)
Knowledge on prevention of COVID-19		
	By wearing a well-fitting face mask.	278(80.8)
	By wearing clothes or general medical masks by ordinary people.	158(45.9)
	By Regular washing hands with soap and water, and also using disinfectants.	299(86.9)
	By stay at home and maintaining social distance	306(89.0)
	By Maintaining a distance of at least 1 meter between everyone.	262(76.2)

RESULTS

Table 1 show a total of 344 participants, majority (38.4%) were in the age group of 26-30 years and lowest (3.8%) were in the age group of above 51-55 years. The mean age of participants was 30.66 years. Concerning gender, most of the participants 52.9% were male. There were 65.7% married participants. Regarding, ethnicity 70.9% belongs to

Brahmin/Chhetri. There were majority participants 84.3% followed Hinduism. Out of 344 participants 43.9% had completed master and above degree education. Majority 42.7% participants had 6-10 years working experience. Most of the participants 92.7% had not received any training regarding COVID-19. The source of information for most of the participants (94.2%) was internet.

In this study, most of participants 57% had good knowledge level with Mean Score ± SD 16.61 ± 4.59. Likewise, 53.2% participants had favorable attitude with mean score 28.86 ± 4.96. Similarly, 51.7% participants had good practice with 8.27 ± 1.45 mean score towards COVID-19. Table 2, show that 98.5% of the participants knew COVID-19 is a highly infectious disease. Most of the participants 95.6% knew the virus is a cause of COVID-19. Regarding transmission mode 100% gave correct response on air likewise shaking hands with an infected person 84%, saliva of an infected person 74.4%, kissing and hugging 72.4%, urine and faeces of an infected person 37.5 % gave correct response. Majority of the participants gave correct response on sign and symptoms of COVID-19 like fever 95.9%, cough 81.7%, difficulty in breathing 78.5% sore throat 68.9% weakness 67.7%, severe headache 59.9%, muscle pain 47.4%, vomiting 40.7%, diarrhea 29.1%, Most of the participants gave correct response on preventive measures of COVID-19, by stay at home and maintaining social distance 89%, by regular washing hands with soap and water, and also using disinfectants 86.9%, by wearing a well-fitting face mask 80.8%, by maintaining a distance of at least 1 meter between everyone 76.2%, by wearing clothes or general medical masks by ordinary people 45.9%.

Table 3 shows that knowledge was significantly associated with gender (p=0.042), marital status (p=0.044), COVID-19 training (<0.001), sources of COVID-19 information internet (p<0.001), television (p <0.001), relatives and friend (p=0.003), FM and radio (p<0.001), health worker (p=0.034) and community worker (p=0.027). Attitude towards COVID-19 was significantly associated with ethnicity (p=0.008), education (p=0.009) and sources of information internet (p=.003). Practice was significantly associated with gender (p=0.008), religion (p<0.001), education (p=0.015), teaching experience (p=0.008), sources of information from FM/radio (p=0.038) and community worker (p=0.003).

Table 4 shows that gender male 0.457 (95% CI: 0.256-0.818), COVID Training 25.687 (95% CI 5.354-123.226), COVID-19 information from newspaper 0.377(95% CI: 0.185-0.766), internet 17.447 (95% CI: 2.739-111.130), television 3.052 (95% CI:1.600-5.823), radio/FM 2.507(95% CI: 1.168-5.381) and community worker 3.79 (95% CI: 1.316-10.923) have associated significantly with good knowledge. Regarding attitude, Brahmin/Chettri 0.375 (95% CI: 0.202-0.694), higher education 0.240 (95% CI: 0.111-0.520), information from Internet 5.457 (95% CI: 1.730-17.207) have associated significantly with good attitude. Concerning practice, gender male 1.848 (95% CI: 1.086-3.146), Hinduism 0.389

(95% CI: 0.170-.891), higher education bachelor 2.543 (95% CI: 1.223-5.288), master and above 1.916 (95% CI: 1.074-3.418), teaching experience 6-10 years 3.278 (95% CI: 1.145-9.379), sources of information from internet 4.473 (95% CI: 1.371-14.596), radio/FM 0.430 (95% CI: 0.215-0.860), community worker 2.619 (95% CI: 1.124-6.098) have associated significantly with good practice.

Pearson correlation tests revealed a statistically significant positive correlation between knowledge-practice (r=123, p < 0.02) and practice attitude (r=117, p=0.03) and negative correlation between knowledge attitude (r = -036, p > 0.05).

DISCUSSION

Several studies have been conducted on COVID-19 knowledge among the general population and healthcare workers but no existing literature on the same topic were found after extensive literature search by using different combination of keywords. To our best knowledge, this is the first study that has been conducted with the purposes to assess the level of knowledge, attitude, and practice towards the COVID-19 among private schools teachers in Chitwan district Nepal.

In this study, some socio-demographic factors that are associated with good knowledge, attitude, and practices towards COVID-19 among school teachers found that most of the participants have good knowledge attitude and practice towards COVID-19. There were significant associations between some socio demographic factors like age, gender, marital status, educational level. These findings are supported by the study conducted in Nepal, China, Bangladesh, Tanzania and India.[9-13]

In the present study, it is revealed that 57% of the participants have good knowledge towards COVID-19. However, this score is much lower than that reported by (68.4%) Vietnam, (80.64%) India, (84.25%) Nepal, (84.4%) Tanzania and (90%) China.[9,10,12-14] This is possibly because these studies assessed COVID-19 symptoms, mode of transmission using one direct question rather than asking the participants to choose from multiple responses. Also, the study participants were health professionals majorly. In this study, Virus as a cause of COVID-19 was the question with the highest correct answers (95.6%), this finding is supported by study conducted in (95.4%) Birgunj, Nepal.[15] More than 80% of the participants gave correct responses on major three symptoms of COVID-19 like Fever (95.9%), Cough (81.7%), and Difficulty in breathing (78.5%) these findings were supported by the study done in various countries, like in Iran.[16] Major symptoms found difficulty in breathing' (93.3%), 'fever' (90.9%) and 'cough' (83.2%), similar type findings showed by study done in China and India too.[10,13] This is possible that people are highly aware of Coronavirus due to information in the mass media, including radio, television, social media, friend's relatives and official authorities. Regarding mode of transmission of

Table 3. Association Between KAP Level Towards COVID-19 and Socio-demographic Variables (n=344)

Variables	Level of Knowledge			Level of Attitude			Level of Practice		
	Good (%)	Poor (%)	p-value	Favorable (%)	Unfavorable (%)	p-value	Good (%)	Poor (%)	p-value
Age in group									
20-30 years	109(54.8)	90(45.2)		100(50.3)	99(49.7)		104(52.3)	95(47.7)	
31-55 years	87(60)	58(40)	0.334	83(57.2)	62(42.8)	0.199	74(51)	71(49)	0.822
Gender									
Male	113(62.1)	69(39.9)		96(52.7)	86(47.3)		82(45.1)	100(60.2)	
Female	83(51.2)	79(48.8)	0.042	87(53.7)	75(46.3)	0.895	96(59.3)	66(40.7)	0.008
Marital status									
Unmarried	76(64.4)	42(35.6)		68(57.6)	50(42.4)		63(53.4)	55(46.6)	
Married	120(53.1)	106(46.9)	0.044	115(50.9)	111(49.1)	0.234	115(50.9)	111(49.1)	0.659
Religion									
Hinduism	170(58.6)	120(41.4)		158(54.5)	132(45.5)		162(55.9)	128(44.1)	
Other than Hindu	26(48.1)	28(51.9)	0.154	25(46.3)	29(53.7)	0.268	16(29.6)	38(70.4)	<0.001
Ethnicity									
Brahmin Chettri	144(58.5)	102(41.5)		142(57.7)	96(42.9)		139(56.5)	107(43.5)	
Other than Brahamin Chettri	52(53.1)	46(46.9)	0.355	41(41.8)	57(58.2)	0.008	39(39.8)	59(60.2)	0.005
Education									
Secondary	26(45.6)	31 (54.4)		40(70.2)	17(29.8)		21(36.8)	36(63.2)	
Bachelor	83(61)	53(39)	0.140	73(53.7)	63(46.3)	0.009	68(50)	68(50)	
Master and above	87(57.6)	64 (42.4)		70(46.4)	81(53.6)		89(58.9)	62(41.1)	0.015
COVID Training									
Yes	3(12)	22(88)		11(44)	14(56)		17(68)	8(32)	
No	193(59.1)	126(40.9)	<0.001	172(53.9)	147(46.1)	0.339	161(50.5)	158(49.5)	0.091
Teaching Experience									
< 1-5 years	54(56.8)	41(43.2)		46(48.4)	49(51.6)		39(41.1)	56(58.9)	
6-10 years	75(51)	72(49)		81(55.1)	66(44.9)		73(49.7)	74(50.3)	
11-15 years	23(82.1)	5(17.9)	0.031	21(75)	7(25)	0.099	15(53.6)	13(46.4)	0.008
16-20 years	27(55.1)	22(44.9)		22(44.9)	27(53.1)		35(71.4)	14(28.6)	
> 20 years	17(68)	8(32)		13(52)	12(48)		16(64)	9(36)	
Sources of information									
Newspaper	81(60.9)	52(39.1)	0.243	71(53.4)	62(46.6)	0.956	69(51.9)	64(48.1)	0.968
Internet	194(60.2)	128(39.8)	<0.001	178(55.3)	144(44.7)	0.003	170(52.8)	152(47.2)	0.136
Television	111(69.8)	48(30.2)	<0.001	83(52.2)	76(47.8)	0.731	83(52.2)	76(47.8)	0.875
Relatives and friend	75(68.8)	34(31.2)	0.003	55(50.5)	54(49.5)	0.488	49(45)	60(55)	0.860
Radio/FM	80(76.9)	24(23.1)	<0.001	58(55.8)	46(44.2)	0.529	45(43.3)	59(56.7)	0.038
Health worker	52(67.5)	25(32.5)	0.034	40(51.9)	37(48.1)	0.803	44(57.1)	33(42.9)	0.282
Community worker	35(71.4)	14(28.6)	0.027	26(53.1)	23(46.9)	0.984	35(71.4)	14(28.6)	0.003

%percentage *multiple response   p value of less than 0.05 considered significant.

COVID-19, most of the participants gave correct response through air (100%), shaking hands with an infected person (84%), Saliva of an infected person (74.4%) and kissing and hugging (72.4 %) these findings were supported by the study done in Iran.[16] Whereas, shaking hands with an infected person (91.9%), kissing and hugging (90.1%), and being in contact with the saliva of an infected person (87.2%).

Moreover, the results of present study shows, 53.2% of people have good attitude which is lower than other studies done in (97.33%) India and (80%) Malaysia.[17] These studies used only 2 questions in three point likert scale but in our study we used 5 point likert scale with more attitude items related to schools and students. Most of the participants (31.7%) strongly agreed that children and young adults

Table 4. Logistic regression analysis for Socio-demographic factors associated with KAP towards COVID-19   (n=344)

Variables	Level of Knowledge		Level of Attitude		Level of Practice	
	Good	Poor	Favorable	Unfavorable	Good	Poor
	COR (95% CI)	p-value	COR (95% CI)	p-value	COR (95% CI)	p-value
Gender (Male vs female*)	0.457(0.256-0.818)	0.008	1.312(0.785-2.193)	0.300	1.848(1.086-3.146)	0.024
Marital status (unmarried*vs married)	0.699(0.401-1.218)	0.206	0.784(0.476-1.291)	0.339	1.163(0.689-1.964)	0.571
Religion (Hindusism vs other* religion)	1.247(0.531-2.932)	0.613	1.138(0.522-2.478)	0.745	0.389 (0.170-.891)	0.026
Ethnicity (BrahminChettri vs Others*)	0.677(0.347-1.319)	0.252	0.375(0.202-0.694)	0.002	0.765(0.415-1.410)	0.390
Education (bachelor vs Secondary*)	1.703(0.785-3.696)	0.178	0.240(0.111-0.520)	<0.001	2.543(1.223-5.288)	0.012
(Master vs Bachelor*)	1.679 (0.901-2.3.129)	0.103	0.637(0.371-1.093)	0.101	1.916(1.074-3.418)	0.028
COVID Training (Yes vs No*)	25.687(5.354-123.226)	<0.001	1.076(0.388-2.985)	0.888	0.551(0.167-1.819)	0.328
Teaching Experience <1-5 years* vs 6-10years	2.549(0.847-7.669)	0.096	0.973(0.374-2.531)	0.955	3.278(1.145-9.379)	0.027
6-10 *years -11-15 years	2.650(0.895-7.844)	0.078	0.903(0.356-2.288)	0.829	1.583(0.568-4.414)	0.380
11-15 *years vs 15-20 years	0.294(0.058-1.496)	0.140	0.319(0.083-1.223)	0.096	0.930(0.247-3.499)	0.914
>15-20* years vs >20years	2.137(0.585-7.804)	0.251	1.074(0.355-3.244)	0.900	0.718(0.213-2.415)	0.592
Sources of information Newspaper (yes vs no*)	0.377(0.185-0.766)	0.007	1.299(0.723-2.332)	0.382	1.128(0.602-2.114)	0.706
Internet(yes vs no*)	17.447(2.739111.130)	0.002	5.457(1.730-17.207)	0.004	4.473(1.371-14.596)	0.013
Television(yes vs no*)	3.052(1.600-5.823)	0.001	0.905(0.509-1.608)	0.733	1.341(0.726-2.480)	0.349
Relative (yes vs no*)	1.247(608-2.557)	0.547	0.785(0.429-1.436)	0.432	0.671(0.348-1.295)	0.234
Radio/FM(yes vs no*)	2.507(1.168-5.381)	0.018	1.242(0.649-2.378)	0.513	0.430(0.215-0.860)	0.017
Health worker(yes vs no*)	1.307(0.593-2.882)	0.507	0.966(0.515-0.515)	0.915	1.340(.675-2.662)	0.403
Community worker (yes vs no*)	3.791(1.316-10.923)	0.014	0.997(0.460-2.160)	0.993	2.619(1.124-6.098)	0.026

Reference group* OR: Odds Ratio; CI: Confidence Interval
p value of less than 0.05 is considered significant.

Table 5. Correlation between KAP Scores

Variables	Correlation coefficient (r)	p- value
Knowledge- practice	123*	0.02
Knowledge- attitude	-036*	>0.05
Practice-attitude	117*	0.03

*Correlation is significant at the 0.05 level (2-tailed)

are not vulnerable and (36.6%) strongly agreed after COVID-19 infection people become normal and productive. This finding is supported with study done in Malaysia.[17] Likewise; majority participants (25.9 %) strongly disagreed with answers 'Students who survived COVID-19' put others in class at risk of infection. Most of the participants (49.1%) agreed that 'Isolation and treatment' are effective in reducing the spread of virus and school closure can help to control spread up and outbreak of COVID-19 by reducing transmission as said by UNESCO.[18] Likewise, most of the participant (28.5%) agreed that Schools should not be opened till vaccines are available for COVID-19. But interestingly some participants (33.4%) agreed that tele-learning does not promote social distancing and schools must reopen.

The findings of present study suggest that (51.7%) half of the participants have good knowledge. However, their attitude and practices towards COVID-19 were not as impressive which is supported by study in (54.87%) Bangladesh.[11] In the current study, 98.5% practicing proper hand hygiene in (92.5%) Iran.[16] Most participants (94.8%) reported taking precautions such as avoiding crowded places this finding is supported by study in (96.4%) China, Nigeria and (93.1%) Nepal.[9,10,19] In this study only 79% wear face mask when leaving the home when going out in (98.0%) China.[10] In this study, most of the participants (67.4%) covered their nose and mouth with bent elbow or a tissue when they cough or sneeze, avoid touching the eyes and nose with hands as recommended by WHO.[20] In this study some participants (35.5%) had taken vitamin c and other immune booster to prevent themselves from COVID-19 infection this finding is supported by study conducted in India.[13] Majority of teachers (79.1%) had taken their classes through online to promote social distancing as said by UNESCO.[18]

This study was conducted in one district of Nepal. The findings may not be generalized in other districts. Since the study was conducted online and those who don't have an internet facility, could not get a chance to enroll in the study.

CONCLUSION

As a conclusion, it is possible to indicate that the knowledge about COVID-19 among the teachers was good, attitudes have been mostly favorable, and the practices are mostly adequate. However, the good knowledge is not the only factor for better attitude and good practice. It is necessary to implement massive education campaigns, trainings and information via school authorities or health authorities who can be helpful in reducing misconceptions and the stigma around recovered patients in the society. Public and private school authorities should emphasis to public and students' health measures by developing and adopting appropriate guidelines.

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