

Review Article

The Current State of Health and Personal Hygiene Education for Children of the Ruc Ethnic Minority (Chut Group) in Quang Binh Province, Vietnam

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Article History

Received: 15.05.2025

Accepted: 22.05.2025

Published: 18.06.2025

Journal homepage:

<https://www.easpublisher.com>

Quick Response Code



Abstract: This study investigates the current state of health and personal hygiene education for children of the Ruc people (a subgroup of the Chut ethnic group) - a tiny ethnic minority facing significant challenges related to their living conditions in Quang Binh Province, Vietnam. This issue is of critical importance given the high rates of malnutrition, hygiene-related diseases, and limited access to healthcare and educational services among Ruc children. This research employed sociological survey methods, incorporating questionnaires, interviews, and classroom observations. Data were collected from education administrators, teachers, healthcare staff, and parents of the children. The collected data were then processed and analyzed using SPSS software. The findings of this study provide a crucial scientific foundation for proposing intervention programs tailored to the socio-cultural context of the Ruc community. Such programs aim to enhance the effectiveness of health education and promote the holistic development of these ethnic minority children.

Keywords: Education, health education, personal hygiene, Ruc ethnic minority, Chut ethnic group.

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1. INTRODUCTION

Ensuring children's health is a fundamental cornerstone of sustainable development, contributing to an improved quality of life, the reduction of inequality, and the promotion of lifelong learning opportunities (United Nations, 2015). Within this framework, health and personal hygiene education play a vital role in fostering positive awareness and behaviors related to self-care, disease prevention, and the adoption of healthy lifestyles from an early age (WHO, 2021). In Vietnam, despite significant progress in health and education policies, substantial disparities in access to basic services persist between ethnic minority children and their urban counterparts (UNICEF Vietnam, 2020). Among these groups, the Ruc people - a subgroup of the Chut ethnic group residing primarily in Thuong Hoa Commune, Minh Hoa District, Quang Binh Province-represent a particularly vulnerable community, characterized by challenging living conditions, inadequate access to healthcare and educational services, and significant cultural and linguistic barriers.

Ruc children currently face numerous serious health issues, including malnutrition, helminthiasis (parasitic worm infections), diarrhea, and skin diseases, which largely stem from a lack of fundamental

knowledge and skills in personal hygiene and healthcare. The malnutrition rate among this group ranges from 25% to 40%, a figure several times higher than that of children in more developed regions (National Institute of Nutrition, 2022). Although the government has implemented policies such as the National School Health Program, their execution within the Ruc community is constrained by geographical barriers, resource scarcity, and the absence of intervention models tailored to the local socio-cultural context (Government of Vietnam, 2021; The Politburo of the Central Committee of the Communist Party of Vietnam, 2023; Ministry of Education and Training, 2021).

To date, there has been a lack of systematic and current research on the state of health and personal hygiene education for Ruc children, as well as on the factors influencing the effectiveness of existing educational programs. Therefore, it is essential to investigate, evaluate, and propose appropriate solutions to this specific context. Such research is necessary to provide a scientific basis for sustainable interventions, thereby contributing to the protection of children's rights and the promotion of equity in access to healthcare and education.

2. Research Content

2.1. Background on the Ruc people (Chut ethnic group) in Quang Binh Province

The Ruc people, a subgroup of the Chut ethnic group, primarily reside in three villages - Mo O O O, On, and Yen Hop - located in Thuong Hoa Commune, Minh Hoa District, Quang Binh Province, with a population of only a few hundred individuals. Before 1959, they led a nomadic, slash-and-burn agricultural lifestyle before being encouraged by the government to settle and transition to agriculture. The traditional culture of the Ruc people is deeply intertwined with nature-based beliefs and indigenous knowledge, although it is gradually eroding due to modernization.

Children in the community attend Thuong Hoa No. 2 Kindergarten, which operates three satellite schools to serve different areas. As of April 2025, the community had 145 children under the age of five, of whom 80 (55.2%) were enrolled in kindergarten. The fact that nearly half of the children lack access to early childhood education reflects a concerning situation, especially in the context of a steadily growing young population. The malnutrition rate among Ruc children under five has decreased from 44% (2020) to 39.2% (2024), yet this improvement remains limited. Malnutrition is often accompanied by other health issues such as diarrhea, helminthiasis, and skin diseases, which are closely linked to poor personal hygiene. Many children have not adopted basic hygiene habits, including infrequent bathing, wearing soiled clothes, and going barefoot, thereby increasing their risk of infection and impairing nutrient absorption (Thuong Hoa Commune Health Station, 2025). According to the National Institute of Nutrition, the prevalence of diarrhea among ethnic minority children, including the Ruc, is twice as high as that of other ethnic groups. The rates of underweight and stunting range from 25% to 40%, which is three to four times higher than among urban children. Malnutrition not only hinders physical and intellectual development but also adversely affects academic performance and the ability to remain in primary school (Ministry of Health of Vietnam, 2019).

Despite several support programs from the government, Quang Binh province, and non-governmental organizations, their effectiveness remains limited due to a lack of adaptation to local conditions and culture. Given the rising child population, improving healthcare and education is an urgent necessity. However, significant barriers to accessing basic services persist. Therefore, it is crucial to develop and implement health and education intervention programs tailored to the unique socio-cultural and ecological characteristics of the Ruc people. Only when policies are rooted in a deep understanding of the community's specific context can sustainable, equitable, and substantive change be achieved.

Health and personal hygiene education for Ruc children faces numerous systemic challenges. Although this content is integrated into the kindergarten curriculum, its implementation is not systematic or regular due to a lack of suitable materials, limited facilities, and uneven teacher capacity. Knowledge transmission by teachers is often formalistic, as they have not received training specific to the Ruc's cultural context and living conditions. Children have limited exposure to visual aids and experiential learning activities, while families, constrained by difficult living conditions and limited awareness, do not prioritize instilling personal hygiene habits. Furthermore, the limited access of Ruc children to early childhood education and primary healthcare stems from economic disadvantages, environmental factors, geographical distance to educational and medical facilities, and parents' limited awareness of the importance of early education, nutrition, and personal hygiene. An imbalanced diet, largely dependent on natural food sources of questionable sanitation, coupled with a shortage of essential hygiene supplies and appropriate medical services, exacerbates the risk of malnutrition and disease among young children. With a stunting rate consistently above 30% - higher than the provincial average - the Ruc community demonstrates a high level of vulnerability and requires priority in investment programs for education, health, and living condition improvement to ensure the holistic and sustainable development of its children.

Consequently, to enhance the health and holistic development of Ruc children, in-depth research on health and personal hygiene education is essential. Such research will provide the scientific foundation needed for developing effective and sustainable intervention programs.

2.2. Research instrument design

To assess the current state of health and personal hygiene education for Ruc children in Quang Binh Province, the research team surveyed a total of 14 kindergarten administrators and teachers, 6 healthcare staff, and 25 parents. The primary survey instrument was a questionnaire. The collected data were processed and analyzed using SPSS software. A four-point Likert scale was used for evaluation, with corresponding scores of 1, 2, 3, and 4. Each level was defined by a specific mean range (Poor: $1 \leq M \leq 1.74$; Average: $1.75 \leq M \leq 2.49$; Good: $2.50 \leq M \leq 3.24$; Excellent: $3.25 \leq M \leq 4.00$).

To enhance the reliability of the research findings, supplementary qualitative methods were employed, including classroom observations, interviews, and discussions with administrators, kindergarten teachers, healthcare staff, and parents.

2.3. Survey results on the current state of health and personal hygiene education for Ruc children (Chut ethnic group) in Quang Binh Province

2.3.1. The Implementation of health and personal hygiene education objectives for Ruc Children

Based on the data presented in Table 1, the following observations can be made:

The group of kindergarten administrators and teachers assigned the highest rating to the objective related to forming hygienic eating habits and promoting healthy physical activity ($M=3.12$). In contrast, objectives concerning infectious disease prevention and the development of personal self-care skills received lower ratings, indicating a clear need to strengthen these components within the educational program.

Healthcare staff tended to prioritize objectives related to general prevention and awareness-raising. However, the objective of "equipping children with knowledge about infectious diseases" scored a low mean ($M=1.95$), suggesting that this group may perceive this content as either ineffectively implemented or not developmentally appropriate for the children.

Parents highly valued the objective related to diet and physical activity ($M=3.08$), which is consistent with the professional groups' assessments. However, their ratings for the remaining objectives were only average to fair ($M\approx 2.15-2.48$), reflecting either hesitation or limited awareness regarding the role of personal hygiene education in children's health.

Regarding the level of implementation, the objective "Fostering hygienic eating habits, physical exercise, appropriate physical activity, and avoiding bad habits" received the highest ratings, with mean scores ranging from 2.99 to 3.12. Conversely, the objective "Equipping children with knowledge and skills about common infectious diseases and their prevention" had the lowest mean scores ($M=1.87-2.15$).

In terms of consensus level, the kindergarten administrators and teachers demonstrated high consistency in their assessment of the objective "Educating children on daily personal hygiene skills" ($SD=0.23$). In contrast, the parent group showed significant variation in their evaluations of the objectives "Educating children on knowledge and skills for maintaining environmental hygiene" and "Instilling basic hygiene habits such as proper handwashing, tooth brushing, and bathing," as indicated by the highest standard deviation ($SD=0.60$).

Overall, the results indicate that objectives related to forming healthy lifestyle habits have been implemented with relative effectiveness, whereas content on infectious disease prevention remains significantly underdeveloped. The variation in ratings among the different respondent groups underscores the need for enhanced collaboration between schools, healthcare staff, and families to improve the efficacy of health education for preschool children.

Table 1: Implementation of Health and Personal Hygiene Education Objectives for Ruc Children

Objectives	Survey Participants					
	Administrators and Teachers		Healthcare staff		Parents	
	M	SD	M	SD	M	SD
1. Helping children understand the importance of personal hygiene and factors affecting health	2,52	0,53	2,55	0,51	2,48	0,60
2. Instilling basic hygiene habits (e.g., proper handwashing, tooth brushing, bathing)	2,20	0,23	2,33	0,30	2,48	0,60
3. Equipping children with knowledge of infectious diseases and effective prevention	1,87	0,45	1,95	0,40	2,15	0,34
4. Encouraging a healthy diet, regular physical activity, and avoiding bad habits	3,12	0,45	2,99	0,40	3,08	0,43
5. Developing self-care skills to enhance confidence and health management	1,97	0,40	2,24	2	2,36	0,32

2.3.2. Implementation of Health and Personal Hygiene Education Content

Analysis of the data from Table 2 reveals that health education topics such as hygiene habits, sleep and rest, disease prevention, and physical activity were rated at a low-to-average level (level 2), reflecting limited practical implementation. Kindergarten administrators and teachers tended to provide higher ratings compared to parents and, in some cases, healthcare staff, particularly for content related to disease prevention ($M=2.56$) and sleep/rest ($M=2.52$). In contrast, while parents rated proper nutrition the highest ($M=3.21$), they

demonstrated a lower level of perceived importance for the other topics. Healthcare staff provided relatively consistent ratings, with the highest score given to environmental hygiene ($M=3.15$), reflecting their prioritization of environmental factors in child healthcare. Overall, the consensus on the high importance of nutrition and environmental hygiene suggests these are widely recognized priorities. In contrast, the remaining topics require reinforcement through inter-sectoral collaboration and intensified health communication and education efforts directed at parents and the community.

Table 2: Implementation of Health and Personal Hygiene Education Content for Ruc Children

Objectives	Survey Participants					
	Administrators and Teachers		Healthcare staff		Parents	
	M	SD	M	SD	M	SD
1. Hygiene habit education	2,45	0,53	2,40	0,51	2,48	0,60
2. Proper nutrition	2,87	0,37	2,98	0,40	3,21	0,49
3. Exercise and physical activity	2,51	0,50	2,49	0,54	2,40	0,53
4. Disease prevention	2,56	0,55	2,43	0,50	2,39	0,52
5. Sleep and rest	2,52	0,51	2,40	0,43	2,38	0,40
6. Safety and accident prevention	2,67	0,60	2,76	0,70	2,45	0,41
7. Environmental hygiene education	2,76	0,69	3,15	0,49	3,06	0,49

2.3.3. Implementation of Health and Personal Hygiene Educational Methods

Analysis of the data from Table 3 indicates that the three most effectively rated methods for health and personal hygiene education are:

Emotion-based methods, which received the highest mean score across all three respondent groups, particularly from parents ($M=3.21$), underscore their effectiveness in promoting children's health behaviors.

Learning through play, highly rated by parents ($M=3.20$), reflects its suitability for the developmental stage and its appeal to preschool children.

Daily repetitive practice, which received the highest rating from healthcare staff ($M=3.15$), highlights its sustainability and ability to form positive habits in children.

Conversely, the two methods with the lowest implementation levels are:

Parental involvement, which had the lowest mean score across all groups, especially from

administrators and teachers ($M=1.97$), reflects ineffective collaboration between families and the school.

Assessment and role modeling had low mean scores, indicating a lack of mechanisms for evaluating and positively reinforcing children's behavior.

Notable trends include:

Parents rated emotional, play-based, and practical methods highly, reflecting their support for child-friendly and accessible approaches.

Healthcare staff prioritized repetitive and practical methods, consistent with a preventive health orientation.

Administrators and teachers rated several methods lower, particularly those involving parental participation, suggesting limitations in community mobilization.

Table 3: Current Practices in Health and Personal Hygiene Education for Ruc Children

Objectives	Survey Participants					
	Administrators and Teachers		Healthcare staff		Parents	
	M	SD	M	SD	M	SD
Learning through play	2,88	0,37	2,98	0,40	3,20	0,49
Emotion-based methods	2,86	0,37	2,99	0,40	3,21	0,49
Verbal instruction	2,56	0,55	2,43	0,50	2,39	0,52
Visual and illustrative methods	2,67	0,60	2,76	0,70	2,45	0,41
Daily repetitive practice	2,76	0,69	3,15	0,49	3,06	0,49
Assessment and role modeling	2,20	0,23	2,33	0,30	2,48	0,60
Parental involvement	1,97	0,40	2,24	0,22	2,36	0,32
Using a safe and clean learning environment	2,52	0,53	2,55	0,51	2,48	0,60

2.3.4. Implementation of Health and Personal Hygiene Educational Formats

The survey results in Table 4 reveal notable differences among the three respondent groups in their assessment of the application of health education formats.

Education through play was rated highest by all three groups, especially by parents ($M=3.21$, $SD=0.49$),

indicating a clear preference for experiential and dynamic learning formats.

Formats such as education through formal lessons, videos, practical activities, and festivals were rated at an average level ($M\approx 2.45-2.76$), reflecting a relatively consistent but not prominent level of application.

Creating daily habits was rated higher by parents ($M=2.49$, $SD=0.61$) than by teachers and healthcare staff ($M=2.23-2.30$), highlighting the direct observational role and impact of the family in forming children's hygiene routines.

Education through stories and books was the lowest-rated format, particularly among teachers ($M = 1.97$, $SD = 0.40$), suggesting that this format has not received adequate attention in practice.

Community health education programs were rated quite similarly by all three groups ($M \approx 2.48-2.57$),

indicating that the supportive role of programs external to the school is relatively well-recognized.

In summary, visual and experiential formats (such as play, videos, and hands-on activities) are viewed more positively than indirect methods like storytelling or reading. The differences in ratings among the groups also reflect the unique perspectives and roles of each stakeholder in the child's health education. This highlights the need for more effective coordination among families, schools, and the health sector to synergistically leverage all educational formats appropriate for young children.

Table 4: Implementation of Health and Hygiene Habit Education Formats for Ruc Children

Objectives	Survey Participants					
	Administrators and Teachers		Healthcare staff		Parents	
	M	SD	M	SD	M	SD
Education through formal lessons	2,69	0,60	2,76	0,71	2,45	0,42
Education through play	2,87	0,37	2,98	0,40	3,21	0,49
Education through festivals and events	2,52	0,53	2,55	0,51	2,48	0,60
Teaching via images and videos	2,67	0,60	2,76	0,70	2,45	0,41
Direct practical activities	2,52	0,53	2,55	0,51	2,48	0,60
Creating daily habits	2,23	0,25	2,30	0,28	2,49	0,61
Education through stories and books	1,97	0,40	2,27	0,22	2,36	0,32
Community health education programs	2,52	0,53	2,57	0,51	2,48	0,59

2.4. Underlying Causes

The Ruc people live in isolated mountain areas with poor roads, which makes it very difficult for them to access basic healthcare and education. Their economy is based on self-sufficiency, and combined with low levels of education and limited awareness of personal health, this means hygiene and disease prevention are not given enough attention. A lack of clean water, proper toilets, and basic sanitation systems (like handwashing areas and water drainage) directly affects children's hygiene habits and health. In addition, schools are not evenly distributed. Many school sites, especially the smaller, remote ones, severely lack essential sanitation facilities. This reduces the effectiveness of education and gets in the way of forming good hygiene habits in children.

Educational institutions in the area lack staff who specialize in health and nutrition. This leads to problems in ensuring meals are hygienic and providing basic care, which negatively affects children's health. The teaching staff is often not stable, as many are short-term teachers from other areas who do not understand the Ruc language, culture, or living conditions. This makes it difficult to maintain and improve the quality of health education in schools.

Health education efforts are further complicated by entrenched traditional practices, such as not using soap for handwashing and infrequent tooth brushing - personal hygiene behaviors that are difficult to change. Language barriers and the community's tendency toward social isolation continue to diminish the efficacy of

health communication initiatives. Additionally, letting farm animals roam freely around homes and schools pollutes the environment, increasing the risk of disease and hindering the development of good hygiene habits in children.

Low school attendance and the common use of multi-grade classrooms make it difficult to organize specific health and hygiene activities for different age groups.

Current teaching materials are too general and not suited to the culture, language, or understanding level of Ruc children, which makes it hard for them to learn and use health knowledge.

A major barrier is the limited awareness among parents and adults about the importance of personal hygiene. Low education levels and travel difficulties cause children to miss school often, which affects their learning. Furthermore, the lack of support and positive role-modeling from parents at home reduces the impact of school health programs.

Limited awareness among parents and the wider community regarding the important role of personal hygiene and healthcare constitutes a major barrier to fostering healthy habits in children. Low educational levels, geographical isolation, and transportation difficulties contribute to irregular school attendance, which in turn limits children's ability to absorb essential health knowledge. Moreover, a lack of parental engagement, support skills, and positive role-modeling

in healthcare at home reduces the impact of school-based health programs.

Coordination between key sectors like education, health, and social organizations is disconnected, disorganized, and mostly ineffective. There is a clear lack of intervention programs designed specifically for Ruc children. The partnership between schools and the health sector is weak and not regular or long-lasting. On top of this, there is a lack of long-term, sustainable national policies focused on health and hygiene for very small ethnic groups like the Ruc.

Most current programs are temporary, not in-depth, and have failed to create real, lasting change in the community.

3. CONCLUSION

This study finds that health and personal hygiene education for Ruc children in Quang Binh Province faces significant shortcomings. These problems are mainly caused by system-wide factors, such as difficult economic and social conditions, limited community awareness, and a lack of facilities and expert staff. Although there has been some early progress in areas like nutrition and environmental hygiene, topics like disease prevention and self-care skills are not being taught effectively. The teaching methods and formats are not well-coordinated, and the partnership between schools, health centers, and families is weak, leading to low effectiveness of these efforts. Based on these findings, this research highlights the urgent need to create special education programs that are carefully designed for the Ruc community's unique social and

cultural situation. Such programs are essential to improve the quality of primary healthcare and support the overall development of this particularly vulnerable, small ethnic minority group of children.

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Cite This Article: Cao Thi Le Hang, Pham Thi Yen, Nguyen Thi Cam Nhung, Nguyen Thi Thanh Thuy, Ngo Thi Hoai An, Nguyen Thi Kim Oanh (2025). The Current State of Health and Personal Hygiene Education for Children of the Ruc Ethnic Minority (Chut Group) in Quang Binh Province, Vietnam. *East African Scholars J Edu Humanit Lit*, 8(6), 199-204.
