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5th National Conferences on

RESEARCH METHODOLOGY

Enhancing innovative and futuristic practice in Nursing

4th & 5th July, 2019



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**Proceedings of
5th NATIONAL CONFERENCE
ON**

RESEARCH METHODOLOGY

**ENHANCING INNOVATIVE AND FUTURISTIC PRACTICE IN NURSING
on 4th AND 5th JULY, 2019**

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SUMANDEEP NURSING COLLEGE
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SUMANDEEP NURSING COLLEGE.....

Sumandeep Nursing College takes pride in extending heartily welcome to the wonderful event of 5th National Conference on **RESEARCH METHODOLOGY – Enhancing Innovative and Futuristic Practice in Nursing.**

Sumandeep Nursing College, a constituent institute of Sumandeep Vidyapeeth deemed to be University is affianced in dispersing professional higher education in the field of Nursing more than a decade.



Sumandeep Vidyapeeth, is an institution

deemed to be university, under section 3 of UGC act 1956. The Vidyapeeth has seven constituent institutes imparting knowledge in the field of Medical, Dental, Pharmacy, Physiotherapy, Nursing, healthcare Management, and Paramedical Sciences. It is the first deemed university of Gujarat State, which was started in the year 2007. The vidyapeeth is accredited by NAAC (National Assessment and Accreditation Council) with the CGPA of 3.53 on a four point scale at 'A' Grade, in the year 2015. Recently the university is conferred category – I status by UGC regulation 2018. Sumandeep Vidyapeeth is the Pioneer in Evidence based Education System, adopted in education and Practice.

Sumandeep Nursing College strive hard to develop nursing through education and training, compassionate, professionally excellent, ethically sound individuals who will go out as competent nurse for healing communities. This service may be promotive, preventive, curative, rehabilitative or palliative aspects of Health care. College provides a culture of caring while perceiving its commitments to professional excellence. Sumandeep Nursing college is committed to innovation and adoption of new, appropriate, cost-effective, caring technology.

Sumandeep Nursing college absorbs the clinical resources to facilitate the learning needs of nursing students at Dhiraj Hospital, which is a constituent of Sumandeep Vidyapeeth with 1360 bedded Multi- specialty hospital.

About the conference:

Research is a major force in Nursing, and the evidence generated from research is changing practice, education, and health policy. Our aim of organizing this program was to create an excitement, instill extracurricular research information, explore the areas of conducting research, application of evidence based nursing practice, demystify the difficulties in Research and statistics, use statistical applications, encounter the ethical issues, use the appropriate channel for dissemination of research outcomes among undergraduate, post graduate, research scholars as well as faculty of Nursing profession. This emphasize the importance of being able to read, critique, conduct, guide and communicate the research so that, such evidences can be used to make changes in the practice.

A major goal of professional nursing and health care is the delivery of Evidence based care. By making Research an integral part of nursing education we can facilitate the movement of research in to the mainstream of nursing. We hope this scientific session increases Nurses awareness of the knowledge that has been generated through nursing research and that this knowledge is relevant to the practice.

Subthemes of the Conference:

- ✓ *Identify Research Problem Thrust Areas*
- ✓ *Scope And Significance Of Research In Nursing*
- ✓ *Dissemination And Communication Of Research*
- ✓ *Research Review, Sources And Writing*
- ✓ *Forms Of Transitional Research And Field Projects*
- ✓ *Overview To Qualitative Research And Mix Methods*
- ✓ *Concept Of Systematic Review And Meta - Analysis*
- ✓ *Qualitative Research Methods*
- ✓ *Exploring The Concept Of Bioethics*
- ✓ *Data Interpretation And Analysis In Research*

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Scientific Paper Presentations



Poster Presentations
RMEIFPN – JULY - 2019



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**National Conference on
Research Methodology
(Enhancing Innovative and Futuristic Practice in Nursing)
4th & 5th, July - 2019**

Organized by
Sumandeep Nursing College (A Constituent of Sumandeep Vidyapeeth), Piparia, Vadodara, Gujarat, India

“Research Methodology - Enhancing Innovative and Futuristic Practice in Nursing”

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Sumandeep nursing college has been organizing several faculty and student development programme frequently. College organizes the seminar, conference, workshops and has been a voice of reason for the nursing fraternity through such academic programs since its inception.

The present conference on “Research methodology” will cover the predominant areas of Research and Statistics by the renowned Researchers of the Nation. Over these two days, this conference will explore the methods and methodology of Research.

Research is "creative and systematic work undertaken to increase the stock of knowledge, including knowledge of humans, culture and society, and the use of this stock of knowledge to devise new applications. It is used to establish or confirm facts, reaffirm the results of previous work, solve new or existing problems, support theorems, or develop new theories.

Research is a process of steps used to collect and analyze information to increase our understanding of a topic or issue". Consisting mainly of three steps: posing a question, collecting data to answer the question, and presenting an answer to the question.

Objectives of the conference are:

- a) To review some basic principles of research methodology
- b) To understand the process of review of literature.
- c) To choose & execute appropriate research design.
- d) To plan/ design an appropriate and adequate research project.
- e) To access to various ways of research dissemination and publication
- f) To understand and apply statistics relevant to research.
- g) To provide an opportunity to build networks with other academics and experts in similar field.

The preambles of this conference are:

1. Great deal today is “digital.” The commercial producers' call for application of emerging software, application and networking to create digital environment to fit into the research.
2. Research is not only to the personal, academic or commercial interest but also to the clinical, applied or outcome research best suited to the clinical practice.
3. Researcher focus on research funding, accreditation, Affiliation, Association, dissemination and patent with various governmental and non-governmental agencies for its wide coverage. Engage with the Govt, private sector and more cooperative ventures that generate data that are valuable to society to generate the health related data.
4. To face the problems and challenges in Nursing research: Fallibility of disciplined research, handling multiple variable, difficulty in control of external variable, Minimal possibility of laboratory research, Lack of standardized tools, Ethical Constraints, Lack of interest among researchers, Lack of qualitative research expertise.
5. To grab the Opportunities to prevailing & to fill the requirement of Nurse researcher:
6. Heighten the focus on EBP: concentrate effort to use research findings in practice.
7. Expanded local research in health care setting : concentrate effort to use research findings in practice.
8. Strengthening of multidisciplinary collaborations: interdisciplinary collaboration of nurse with researchers in related fields is likely to continue to expand in the upcoming years.

9. Expanded dissemination of research findings: the internet and other electronic communication have a big impact on dissemination of research information.

I am very sure that this conference yields fruitful results for the nursing and other faculty, we are thankful to the resource persons, Chairpersons, Evaluators, GNC observers, paper presenters, poster presenters and delegates happy to be participating and we look forward to the contribution to conference proceedings also.

I want to thank the Sumandeep Vidyapeeth providing me to conduct this conference and to give these remarks this conference. And I sincerely thank HOI and faculty of our sister concern institution for its enormous contribution in making this conference possible.

- Dr. Ravindra H.N.
Principal
“Sumandeep Nursing College
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**National Conference on
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“Concept of Ethics in Research – An Overview”

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Introduction:

Research and Development has been the key area for the growth of pharmaceutical and medical device industries as well as academic sector. The pharmaceutical research involves pre-clinical trials and clinical trials with aim of safety and efficacy of investigational new drug proposed to be launched in market for public use, whereas the academic research aims at sensitization with various research methodologies and outcome identification. The core aim of research shall be healthy community. Sometimes, in the race of commercial expediency or mediocre knowledge base, the core purpose is overlooked upon. This is where the research ethics plays a vital role and thus becomes the backbone of any research. Cornerstone documents for research ethics include Nuremberg's Code, Declaration of Helsinki and Belmonte Report and National Ethical Guidelines for Biomedical and Health Research involving Human Participants by Indian Council of Medical Research (2017), to name a few.

History:

The inception of advocacy for ethics in research started after inhuman experiments on Nazi prisoners in 1945, which led to extensive suffering and a huge cry against it. Nuremberg's Code was the regulatory document developed in 1947 to regulate such unethical research activities. It included ten principles to ensure rational, effective and safe research in proper manner of human participants and also to prevent future abuse. There was another document released in 1949 with unanimous efforts of physicians gathered at World Medical Assembly (WMA) known as Declaration of Geneva. However, its unclear language raised applicability concerns and thus was subjected to undergo several revisions. The final version was approved in 1964 as was known as Declaration of Helsinki. Apart from reinforcing basic principles of safety and rationality in research based on evidence, it emphasized on voluntary nature of subject's participation in the trials after being informed each and every aspect of the scientific study to be conducted. It also focused on special considerations while taking consent from “economically and medically disadvantaged” or vulnerable population. It described the scope of combining research and clinical care if the research was found to have potential for diagnosis, prophylaxis or treat. Thereafter, in 1979, Department of Health and Human Services, US released a document entitled Ethical Principles and Guidelines for the Protection of Human Subjects of Research, which latter came to be known as Belmonte Report.

Key Concepts in Research Ethics:

Three key concepts of research ethics were described in the Belmonte Report: 1. Autonomy (Respect to Subjects) 2. Justice 3. Benefit. Thus, adding the basic principle of medical ethics-“Do no harm (Hippocratic Oath) with former three principles could be considered as foundation for research ethics. It is imperative for any research ethics committee to ensure the compliance of any study protocol with these key concepts.

Autonomy: According to this concept, utmost respect should be given to subjects' rights and values by the study investigator. He/ She is responsible to explain the study to the participant in detail while informed consent process so that the participant could participate on pure voluntary basis without any coercion or fear. Participant for any study should be given freedom to withdraw from the study if they do not wish to continue. The informed consent process has participant information sheet (PIS) and informed consent form (ICF). PIS has comprehensive information about study objective, methods, potential risks and likely benefits. Participant should be given provision to clarify his/her doubts before signing informed consent form. There is also provision of Legally Acceptable Representative (LAR) in case the subject does not seem in a position to give voluntary consent, where patients' relative, guardian or parent could facilitate the decision making to help the subject. However, there are several exceptions where waiver of consent is applicable as per recent ethical guidelines by Indian Council of Medical Research (ICMR) 2017;

- ✓ The waiver is scientifically justified and research could not be carried out practically without the waiver
- ✓ Retrospective studies, where the participants are de-identified or could not be contacted
- ✓ Research on anonymized biological samples/data
- ✓ Certain types of public health studies/ surveillance programmes/ program evaluation studies
- ✓ Research on data available in public domain
- ✓ Research during humanitarian emergencies and disasters, when the participant may not be in a position to give consent

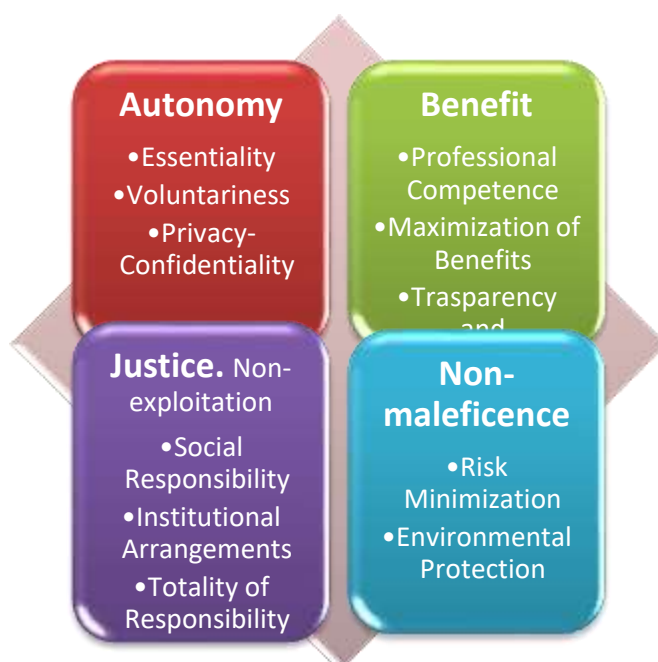
Justice: The concept of justice in ethics refers to the appropriateness and rationality of the research in context of target population. Target population is the group of subjects which has common disease symptoms, clinical condition or characteristics of study interest. The broader definition also refers to the requirement that comparison of experimental medicinal product must be done with standard treatment for that ailment available in the market. It also means that when there is uncertainty about which treatment is better, then and only then a researcher should opt for the comparative study between two drugs. In other words, research should not be conducted to establish the fact which is otherwise already proven.

Benefit: The concept of benefit refers to evaluation of risk-benefit ratio. In any circumstances, the benefits of the clinical trial must outweigh the risks associated with clinical trials. The benefit may be perceived in terms of clinical impact – clinical efficacy or effectiveness of the study drug or even abstract as knowledge gain or knowledge improvement. In case of clinical trials, benefit also means free of cost access and availability to medicinal product and care facilities to the consented participants inclusive of their commutation costs till their study tenure is over. The vital role of evaluation of risk-benefit ratio is played by an independent ethics committee which comprises of mix of institutional and external members from various domains like pharmacology, medicine, legal, social and lay community/ patient group.

Non-Maleficence: Patient safety must be the first and foremost priority in any research. This concept refers to rigorous safety monitoring during course of treatment. If Serious Adverse Event is found to occur, the immediate step to be followed is to report to the Ethics Committee, Sponsor and Central Licensing Authority of the country. It also refers to the requirement to keep rescue medication protocols in hand in case of any adversities during the course of trial. The exclusion of population which is foreseen to have safety issues after study drug administration also corresponds to the same concept. Thus, mention about inclusion/exclusion criteria is the mandatory section of any clinical trial protocol to be reviewed by research ethics committee. Moreover, in case of serious adverse event, it is sole prerogative of ethics committee to decide upon suspend or even terminate the ongoing trial if the safety is found to be significantly compromised to avoid further harm to remaining subjects

ICMR National Ethical Guidelines 2017 mapped with Key Concepts of Ethics in Research:

12 general principles of ICMR ethical guidelines could be mapped with four key concepts as follows:



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Sumandeep Nursing College (A Constituent of Sumandeep Vidyapeeth), Piparia, Vadodara, Gujarat, India

“Understanding Quantitative Research and Mixed Methods Research”

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INTRODUCTION:

The healthcare is an ever growing sector and with the recent advent of technology the revolution in healthcare sector is like an avalanche. The health professionals need to keep abreast themselves with the changes in the care giving as a result of the technology revolution. Nowadays, the data is generated at every step of our daily life and there are analytics available that analyze these data and interpret them to help the health professionals understand the utility of these data. Health professionals must know the various aspects of data for better care giving.

Quantitative research is defined as the systematic investigation of phenomena by gathering quantifiable data and performing statistical, mathematical or computational techniques. Quantitative research gathers information from existing and potential customers using sampling methods and sending out online surveys, online polls, questionnaires etc., the results of which can be depicted in the form of numerical. After careful understanding of these numbers to predict the future of a product or service and make changes accordingly. Quantitative research is by which objectives are tested to understand the various kinds of interactions between the variables. It is a factor that is studied upon either by manipulation or as it is (Wong 2014 p125). The word quantitative implies quantity or amounts. Information collected in the course of the study is in a quantified or numeric form this is referred to as statistical evidence.

An example of quantitative research is, the survey conducted to understand the amount of time a doctor takes to tend to a patient when the patient walks into the hospital. A patient satisfaction survey template can be administered to ask questions like how much time did a doctor take to see a patient, how often does the patient walk into a hospital and other such questions.

The variables include the Dependent variable which is the variable to be predicted and the independent variable is the variable that influences the dependent variable). There may also be Extraneous variables (Polit and Hungler 2013), also known as Confounding variables (White and Millar 2014 p47), which confuse or confound the relationship between the Dependent and Independent variables.

PROCESS OF QUANTITATIVE RESEARCH:

The Problem identification

It should clearly describe what is to be studied. “The hypothesis, aims and/or objectives should be clearly and unambiguously stated. Ideally the topic is narrowed down to a specific one sentence statement of the problem (Nieswiadomy 2012). Ideally four criteria are used in quantitative research namely significance, research ability, feasibility and interest to the investigator” (Moxham 2012 p33).

Review of Literature

“The investigator needs to determine what is known and not known about the problem, identify gaps in knowledge, establish the significance of the study and situate the study within the current body of knowledge (Hoffmann et al 2013)”

Design of Research

Quantitative research falls into four main designs, namely, Descriptive, Correlational, Experimental and Quasi experimental. The descriptive research explains the present situation and characteristics of sample using statistics to describe and summarize the data. Correlational research explains the relationship between two or more variables without any intervention by the researcher. Experimental Research follows the principle of randomized control trial

and comprises of randomization and blinding (Hamer and Collinson 2014 p19).” Quasi experimental research is less powerful than Experimental due to the lower level of control The investigator manipulates an independent variable but subjects cannot be randomised .The choice of design should allow the variable to be measured or manipulated in the study (Burns and Grove 2009). The variables in the study are defined according to the parameters kept for assessment. This is known as operational definition which is different from the conceptual definition.”

Designing the instrument

Quantitative instruments may include self reporting tools, questionnaires, observation, and biophysical measures (Broomfield R).The tool chosen for data collection must be pilot tested for reliability and validity of the tool. This is done to ensure the ability of the study to be generalizable on the population.

Sampling

Descriptive research may use probability sampling which includes simple random, stratified sampling, systematic sampling and cluster sampling (Shaughnessy et al 2014). Random sampling is also known as probability sampling which ensures equal chance to every element to be selected. Quasi-experimental research is called ‘quasi’ because it is part, or almost, experimental. It is less rigorous in design and uses non probability sampling (Polit and Hungler 2013).

Ethical Approval

Most nursing research usually requires the permission of an appropriate ethics committee (Elliott et al 2012 p93; Jirojwong et al 2011 pp63-66). Ethical guidelines outline a set of standards for conducting research. Within their practice nurses have a moral and legal obligation to protect the privacy of an individual.

Pilot Study

A pilot study is a trial run of the research (Nieswiadomy 2012). It is conducted on a small number of participants to assess the adequacy and feasibility of the intended research (Moxham 2012 p35). This helps in strengthening the quantitative methodology.

Main Study

The research process depends on the collection of data known more specifically as empirical data (Moxham 2012 p35) which is rooted in objectivity or a scientific approach (Polit and Hungler 2013). It is at this point that the researcher puts the design into action and ensures that the data is collected and recorded. The findings are analyzed and interpreted through various techniques of hypothesis testing (Borbasi and Jackson 2012 p114).

Hypothesis Testing

Hypothesis is tentative assumption made by the researcher before starting the data collection. The hypothesis are of three types. Researcher Hypothesis is the hypothesis made by the researcher of what he wishes to be the outcome of the study. The second is statistical hypothesis which is put to test using various quantitative data analysis techniques. This statistical hypothesis has two types; one is null hypothesis which states that there is no change in the phenomenon and alternative hypothesis which states something happening in the experiment. The third type of hypothesis is substantial hypothesis which is the hypothesis which is true.

Choice of Statistical Test

Hypothesis testing is carried out by various statistical tests. The choice of these tests depends on the level of data which can be nominal, ordinal, interval or ratio. It also depends on what is the objective of the study and whether sample are related or independent in nature.

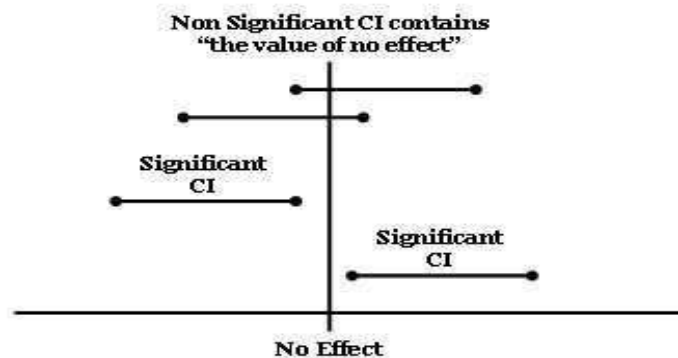
The choice of appropriate test in each level of data is shown in the table 1.

Measurement Scale	One sample case	Two Samples Tests		K samples Test	
		Related Samples	Independent Samples	Related Samples	Independent Samples
Nominal	<ul style="list-style-type: none"> Binomial Chi square one sample test 	<ul style="list-style-type: none"> McNemar 	<ul style="list-style-type: none"> Fisher exact test Chi square two samples test 	Cochran Q	Chi square for k samples

Ordinal	<ul style="list-style-type: none"> Komolgrovsmirnov one sample test Runs test 	<ul style="list-style-type: none"> Signs Test Wilcoxon Matched Pairs test 	<ul style="list-style-type: none"> Median test Mann Whitney Komolgrovsmirnov 	Friedman Two way ANOVA	Kruskal Wallis test
Interval and Ratio	<ul style="list-style-type: none"> T test Z test 	Pair t test	<ul style="list-style-type: none"> T test Z test 	Repeated measures ANOVA	One way ANOVA

Interpreting the Output

The statistical output gives two values; one is p value and other is confidence interval. (CI) - the range within which the true size of effect (never known exactly) lies, with a given degree of assurance. "95% CI" - the interval which includes the true value with 95% certainty. 95% CI represent almost two standard deviations around the mean. *If the 95% or 90% confidence intervals crosses 1, the result is NOT statistically significant (this is because a value of 1 means that there is no difference between the interventions).* Figure 1 illustrates the significant confidence interval



P value is Probability that the results obtained could have occurred by chance. $p = 0.05$ means the probability of chance as an explanation for the observed results is 5% in case confidence level is 95%. $p = 0.10$ in case if CI is 90%.

95% CI gives us information about the whole population than the p-value which gives us information about the sample. ***p value indicates the probability that an outcome this extreme could happen, if the null hypothesis were true.*** As it measures the effect of chance; statistically significant does not mean clinically significant.

Advantages of Quantitative Research

There are many advantages of quantitative research. Some of the major advantages why researchers use this method are:

- Collect reliable and accurate data: As data is collected, analyzed and presented in numbers, the results obtained will be extremely reliable. Numbers do not lie. They present an honest picture of the conducted research without discrepancies and is also extremely accurate. In situations where a researcher predicts conflict, quantitative research is conducted.
- Quick data collection: A quantitative research is carried out with a group of respondents who represent a population. A survey or any other quantitative research method applied to these respondents and the involvement of statistics, conducting and analyzing results is quite straightforward and less time-consuming.
- Wider scope of data analysis: Due to the statistics, this research method provides a wide scope of data collection.
- Eliminate bias: This research method offers no scope for personal comments or biasing of results. The results achieved are numerical and are thus, fair in most cases.

Disadvantages of Quantitative Research

- Does not account for people's thoughts or perceptions about what you're evaluating.
- Does not explore the "why" and "how" behind a phenomenon.

MIXED METHODS RESEARCH:

A mixed method research is one of the three major research paradigms: quantitative research, qualitative research, and mixed methods research. Mixed methods research combines elements of qualitative and quantitative research approaches for the broad purpose of increasing the breadth and depth of understanding. The definition of mixed methods, from the first issue of the Journal of Mixed Methods Research, is "research in which the investigator

collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry” (Tashakkori & Creswell, 2007, p.4).

Recently, there is an increasing popularity of mixed methods research (O’Cathain, 2009). The four major types of mixed methods designs are triangulation design, embedded design, explanatory design, and exploratory design (Creswell & Plano Clark, 2007).

Growth of mixed methods research in nursing and healthcare has occurred at a time of internationally increasing complexity in healthcare delivery. Mixed methods research draws on potential strengths of both qualitative and quantitative methods, allowing the researcher to explore diverse perspectives and uncover relationships that exist between the intricate layers of our multifaceted research questions. As providers and policy makers strive to ensure quality and safety for patients and families, researchers can use mixed methods to explore contemporary healthcare trends and practices across increasingly diverse practice settings.

What is mixed methods research?

Mixed methods research requires a purposeful mixing of methods in data collection, data analysis and interpretation of the evidence. The key word is ‘mixed’, as an essential step in the mixed methods approach is data linkage, or integration at an appropriate stage in the research process. The mixed method research helps the researcher to have a panoramic view of the problem. For example, in a randomised controlled trial (RCT) evaluating a decision aid for women making choices about birth after caesarean, quantitative data were collected to assess knowledge change, levels of decisional conflict, birth choices and outcomes. Qualitative data can also be collected to understand what factors influence their choices. (Allison Shorten, 2017)

When to use Mixed Methods Research?

Four broad types of research situations have been reported as benefiting particularly from mixed methods research. The first situation is when concepts are new and not well understood. Thus, there is a need for qualitative exploration before quantitative methods can be used. The second situation is when findings from one approach can be better understood with a second source of data. The third situation is when neither a qualitative nor a quantitative approach, by itself, is adequate to understanding the concept being studied. Lastly, the fourth situation is when the quantitative results are difficult to interpret, and qualitative data can assist with understanding the results (Creswell & Plano Clark, 2007).

What are the strengths and challenges in using mixed methods?

A mixed methods design is appropriate for answering research questions that neither quantitative nor qualitative methods could answer alone. Mixed methods can be used to gain a better understanding of connections or contradictions between qualitative and quantitative data; they can provide opportunities for participants to have a strong voice and share their experiences across the research process, and they can facilitate different avenues of exploration that enrich the evidence and enable questions to be answered more deeply. Mixed methods can facilitate greater scholarly interaction and enrich the experiences of researchers as different perspectives illuminate the issues being studied.

The process of mixing methods within one study, however, can add to the complexity of conducting research. It often requires more resources (time and personnel) and additional research training, as multidisciplinary research teams need to become conversant with alternative research paradigms and different approaches to sample selection, data collection, data analysis and data synthesis or integration. (Allison Shorten, 2017)

Types of Mixed Methods Research

The first type is explanatory sequential mixed method research. In this research, Quantitative data are collected and analysed first, then qualitative data are collected and analyzed to help explain quantitative data.

The second type is exploratory sequential in which Qualitative data are collected and analyzed first, then quantitative data are collected and used to test findings empirically.

The third type of mixed method research is parallel forms where in the Qualitative and quantitative data collected and analyzed concurrently

The nested type of mixed method research is which can be either qualitative or quantitative or mainly quantitative within which the alternative paradigm is embedded to answer a complementary question.

Using Mixed Methods to Overcome Barriers to Research

Barriers to effective research into chronic pain management among American Indians include the relatively small number of American Indian patients in any circumscribed area or tribe, the limitations of individual databases, and widespread racial misclassification. A mixed methods research approach is needed to understand the complex experience, epidemiology, and management of chronic pain among American Indians and to address the strengths and

weaknesses of quantitative methodologies (large sample size, trends, generalizable) with those of qualitative methodologies (small sample size, details, in-depth).

Role of quantitative data

Previous examination of U.S. national databases has reported a higher prevalence of lower back pain in American Indians than in the general population (35% compared to 26% ;Deyo, Mirza, & Martin, 2002). Thus, at level 1, quantitative administrative data sets representing health care received by American Indians, both across the United States and in broad regions, will be used to evaluate macro-level trends in utilization of health care and in basic outcomes, such as opioid-related deaths.

At level 2, more detailed quantitative Washington state tribal clinic data will be used to identify American Indian populations, evaluate breakdowns in the delivery of care, and identify processes that lead to unsuccessful outcomes. For example, in a study conducted with community health practitioners in Alaska, participants reported low levels of knowledge and comfort around discussing cancer pain (Cueva, Lanier, Dignan, Kuhnley, & Jenkins, 2005).

Role of qualitative data

At level 3, qualitative research through focus groups and key informant interviews will provide even more refined information about perceptions of recommended and received care. These interviews will provide insight into selected immediate and proximal factors. These factors include patients' choice and use of services; attitudes, motivations, and perceptions that influence their decisions; interpersonal factors, such as social support; and perceived discrimination. This qualitative data will shed light on potential barriers to care that are not easily recognized in administrative or clinical records, and thereby will provide greater detail about patient views of chronic pain care.

CONCLUSION:

Mixed methods are increasingly being used in nursing research. Each type of data can be collected and analyzed separately and independently, using the techniques traditionally associated with each data type. Both simultaneous and sequential data collection lend them to team research, in which the team includes researchers with both quantitative and qualitative expertise.

Challenges include the effort and expertise required due to the simultaneous data collection, and the fact that equal weight is usually given to each data type. Thus this research requires a team, or extensive training in both quantitative and qualitative methodologies, and careful adherence to the methodological rigor required for both methodologies. Nursing researchers may face the possibility of inconsistency in research findings arising from the objectivity of quantitative methods and the subjectivity of qualitative methods. In these cases, additional data collection may be required.

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**National Conference on
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4th & 5th, July - 2019

Organized by

Sumandeep Nursing College (A Constituent of Sumandeep Vidyapeeth), Piparia, Vadodara, Gujarat, India

“The Scope and Significance of Research in Nursing Profession”

Mr. Rajesh .P

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Dept of Pediatric Nursing,
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DEFINITION

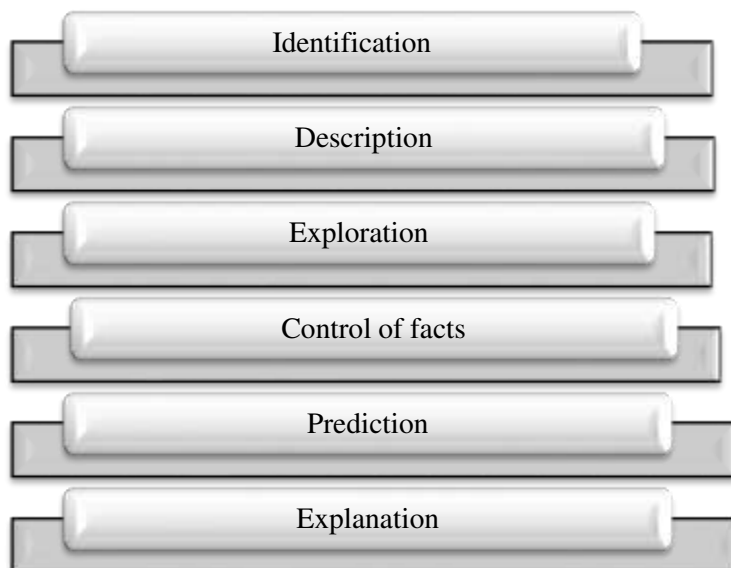
- Nursing research is a key to identify unique knowledge, enhance professional learning and practices and use of materials in a better way

-International council of Nurses 1986

GOALS FOR CONDUCTING NURSING RESEARCH



SPECIFIC PURPOSES OF RESEARCH IN NURSING



SCOPE OF RESEARCH IN NURSING

To strengthen the body of knowledge in

- Nursing Practice

- Nursing Education
- Nursing Administration
- Nursing Informatics

RESEARCH & NURSING EDUCATION

- To test how the contemporary methods of teaching are valid
- It helps in optimizing the skill of nursing students in hospital set up
- Promoting clinical learning strategies of the students
- Rectifying the problems faced during the curriculum period

RESEARCH & NURSING PRACTICE

- Well being, preservation and disease avoidance
- Client protection and value of treatment
- Client – centered care & care coordination
- Enhancing the services with evidences
- Service at community level and family visits
- Disease management and follow up

RESEARCH & NURSING ADMINISTRATION

1. Assess

- Available framework of organization
- Control over the activity
- Communicate
- Organogram, income, profit
- Performance appraisal methods

2. Developing and analysing various administrative models to improve speedy administration and client satisfaction

RESEARCH & NURSING INFORMATICS

Integrates nursing science with multiple information management and analytical sciences to

- Recognize
- Define
- Administer
- Disseminate data, facts, knowledge, and insight in nursing practice.

SIGNIFICANCE OF RESEARCH IN NURSING

- Construct and enhance the body of Nursing knowledge
- Offer health care services more powerfully and resourcefully
- Validate and refine the existing nursing practice
- Provide nurses first hand experiences on which they can build their evidence based nursing practices
- Promise patient safety and prevent injury and illness
- Discard nursing actions that is never achieved the desired care outcome for patients

NURSING RESEARCH - BACKGROUND

- Nursing research has not always had the prominence and importance it enjoys today

It can be discussed under various headings as follows:

- The beginning : Florence Nightingale - 1950's
- During 1960's
- During 1970's
- During 1980's
- During 1990's

THE BEGINNING: FLORENCE NIGHTINGALE - 1950'S

- The nursing research emerged with the lady with the lamp
- She published “Notes on Nursing” explores the interest in ecological factors that enhance physical and emotional health

DURING 1960'S

- Concerns regarding the deficit of research in nursing.
- Professional bodies implemented priorities for research.
- Practice oriented research in various topics.
- Theoretical basis of nursing research began to appear.
- Nursing research established to move on around globe in 1960's.
- The international journal of nursing research began publication in 1963.
- The first Canadian journal of nursing research was first published in 1968.

DURING 1970'S

- Increased number of nurses conduction research.
- Need for the additional outlet for communication emerged.
- A decisive transform in nursing occurred.
- Utilization of the nursing research

DURING 1980'S

- Sum up the number of trained nurses.
- Extensive availability of computers for data collection and analysis of information.
- Growing recognition that research is an integral part of nursing
- New issues and problems rose.
- First volume of annual review of nursing research was published in 1983.
- National institute of health and nursing was established in 1986.

DURING 1990'S

- Nursing science came into its maturity during this period.
- Formation of various nursing research institutions got underway.
- In 1993 the national institute for nursing research (NINR) was born.
- NINR helped to put the nursing research in to the main of the research activities.
- Canadian health service research foundation was established in 1997.
- Several research journals were established during this period.

IN 21ST CENTURY

- The 21st century has seen a blurring of research obstacles and resulted in a significant change in the research arena.
- Evolution of evidence-based practice in Nursing
- Nurses are holding post graduate and higher studies
- Nurses work in a variety of settings, including the hospital, the classroom, the community health department, the business sector, home health care, and the laboratory.
-

CURRENT STATUS OF NURSING RESEARCH IN GLOBAL HEALTH

- It is vital to react on the factors that may negatively influence the progress of nursing research concerned to universal health.

The major problems are:

- (a) Research transparency
- (b) Minimal support

(A) RESEARCH TRANSPARENCY

- Research carried out to deal with universal health issues use of other disciplines and multinational teams
- The transparency of nursing research regarding universal health is influenced by the way in which nurse researchers interested in universal health are well informed and socialized.

(B) MINIMAL SUPPORT

- Nursing research in universal health is restricted by the current nursing research framework
- As a fact, although nursing research has been used to deal with many health problems with a universal component, supplementary follow-up studies are needed to make the evolution to a universal health outlook.

ROLE OF NURSE IN NURSING RESEARCH



RESEARCH PRORITIES FOR THE FUTURE

- Health care needs of high risk groups
- Life satisfaction of individual and families
- Management of physical problems
- Management of disruptive behaviours
- Development of cost effective health care system

DIRECTIONS FOR NURSING RESEARCH IN THE NEW MILLENIUM

- Priority focus on EBP: concentrate effort to use research results in service.
- Rigid evidence base through more precise methods and multiple confirmatory strategies
- Expanded local research in health care setting: small localized research designed to rectify recent problem.
- Reinforcing of multidisciplinary collaborations: interdisciplinary collaboration of nurse with researchers in related fields is possibly to continue to expand in the upcoming years
- Extended dissemination of research results: the web and other search engines have a big impact on dissemination of research inferences.
- Increasing the transparency of the nursing research: generally people are unconscious that nurses are scholars and researchers
- Greater emphasis on systematic review: Is cornerstone to EBP.
- Increased focus on cultural issues and health disparities: it has emerged as an central health concern in nursing.
- This has raised consciousness about the ecological validity and cultural sensitivity of health interventions.

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“A Road Map to Achieve and Sustain Universal Health coverage (UHC)”

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Introduction:

- Health is a human right. No one should get sick and die just because they are poor, or because they cannot access the health services they need.

- **Dr Tedros Adhanom Ghebreyesus**
- Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development. Access to needed health services is crucial for maintaining and improving health. At the same time, people need to be protected from being pushed into poverty because of the cost of health care. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO.

Meaning:

- UHC means that people have access to the health care services that they need without suffering any unnecessary financial burden. UHC is consisting of three interrelated components: the population covered, the range of services made available and the extent of financial protection from the costs of health services.

Definition:

- Assuring equitable access for all peoples, resident in any part of the country, regardless of income level, social status, gender, caste or religion, distance to travel at affordable, accountable, appropriate health services of assured quality (such as promotive, preventive, curative and rehabilitative) as well as public health services which are having sufficient quality to be effective by addressing the wider determinants of health delivered to individuals and populations without any financial problem.

What is UHC:

- UHC means that all individuals and communities should receive the health services when they need without suffering financial problems which includes the full range of vital and quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care.
- UHC enables everyone to access the services and ensures that the quality of those services is good enough to improve the health of the people who receive them at community level.
- UHC protects people from the financial ramification of paying health services from their own pockets.

What UHC is not?

There are many things that are not included in the scope of UHC:

- UHC does not covers for all possible health interventions regardless of the cost, as no country/state can provide all services free of charge on a sustainable basis.
- UHC is not just about health financing but also it incorporates all components of the health system such as health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation.
- UHC is not only about confirming a minimum package of health services, but also about ensuring an advanced extension of coverage of health services and financial protection for people as more resources become available at the health sectors.

- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding places and so on.
- UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.

Challenges for Achieving Universal Coverage:

There are three Fundamental Health Financing Challenges for Achieving Universal Coverage

- Raise sufficient funds for health.
- Ensure/maintain financial risk protection – i.e. ensure that financial barriers do not prevent people using needed health services nor lead to financial ruin when using them;
- Minimize inefficiency and inequity in using resources, and to assure transparency and accountability.

How can countries make progress towards UHC?

Primary health care is the utmost effective and cost effective way to accomplish universal health coverage around the country/world.

- UHC requires solidification in existing health care systems in all countries.
- Robust/Vigorous financing structures are key to achieve and sustain universal health coverage.
- UHC can ensure when administrative will is strong, even if a country is not rich.
- Well-trained, motivated health workers and medicines are essential to achieving UHC.
- Adapting frontline health services is essential for achieving UHC.
- Improving access to medicines through improved procurement and better data.
- Improving health service coverage and health outcomes at community level depends on the availability, accessibility, and capacity of health workers to deliver quality people-centred integrated health care services.
- For achieving UHC, Investments in quality primary health care will be the cornerstone
- Investments in quality primary health care will be the cornerstone for achieving UHC within the country and around the world. Along with that good governance, rigorous systems of procurement and supply of medicines and health technologies and well-functioning health information systems are other critical elements which helps to accomplish UHC.
- In order to train and improve skills among health worker investments are needed from both public and private sectors.
- UHC focused not only what services are covered but also UHC emphasis on how the services are funded, managed, and delivered.
- A fundamental health care services should be integrated and focused on the needs of people and communities which includes reorienting health services to ensure that care is provided in the utmost suitable setting and health services should be organized around the comprehensive needs and expectations of people and communities which will help them empower to take a more active role in their health and health care system.

Can UHC be measured?

- UHC can be measured by following essential health services.
- In order to monitoring progress towards UHC two thing should focus :
 - The proportion of a population that can access essential quality health services.
 - The proportion of the population that spends a large amount of household income on health.
- There are **16 essential health services** in **4 categories** as indicators of the level and equity of coverage in countries, used by World Health Organization

A. Reproductive, maternal, new-born and child health:

- ✓ Family planning
- ✓ Antenatal and delivery care
- ✓ Full child immunization
- ✓ Health-seeking behaviour for pneumonia.

B. Infectious diseases:

- ✓ Tuberculosis treatment
- ✓ HIV antiretroviral treatment
- ✓ Hepatitis treatment
- ✓ Use of insecticide-treated bed nets for malaria prevention
- ✓ Adequate sanitation.

C. Non communicable diseases:

- ✓ Prevention and treatment of raised blood pressure
- ✓ Prevention and treatment of raised blood glucose

- ✓ Cervical cancer screening as early as possible
- ✓ Tobacco chewing and smoking

D. Service capacity and access:

- ✓ Basic health care service accessibility at root level health sectors.
- ✓ Health worker density
- ✓ Access to essential medicines
- ✓ Health security: compliance with the International Health Regulations.

Conclusion:

Each country is distinctive and each country may focus on different areas or develop their own ways of measuring progress towards UHC. But there is also value in a global approach that uses standardized measures that are internationally recognized so that they are comparable across borders and over time. Achieving UHC is one of the targets of the every nations of the world. Countries that advanced towards UHC will make progress towards the other health-related targets and goals.

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“Prevalence of Non-communicable Diseases among Adolescents”

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In 21st century Non-communicable diseases are one of the biggest public health challenges.¹ There are more than 1.2 billion adolescents worldwide, this indicates that nearly one in six persons is an adolescent.² About 243 million population covered by the adolescent in India.³

Young people should understand the Non-communicable diseases and their risk factors. Two out of three premature deaths in adults is due to childhood conditions.⁴ It is estimated that approximately 25 million boys and 13 million girls with age group 13–15 years old smoke cigarettes or use smokeless tobacco products⁵. In 2010 it was found that 81% of adolescents between 11–17 years were inadequately involved in physical activities. Adolescent girls were found to be less active than adolescent boys, with 84% and 78% respectively not meeting the 60 minutes of physical activity per day as per WHO recommendation.⁶

Importance of treating NCDs in adolescents.

Treatment of NCDs is a huge burden not only economically but also huge amount of lives is lost. Thus, it becomes inevitable to prevent NCDs. Prevention of risk factors among young population can prove to be more effective. Adolescence is probably the best age to build positive health habits and limit the harmful behaviors. Adolescents have developing brain and their habits are being formed. Habits formed during this duration are most likely to be maintained through adult life. Thus, it is important to detect and manage harmful behaviors related to NCDs early.⁷

These risk factors can cause less damage if they are recognised early in life when the habits are still forming. This will offer better health, better productivity and lesser cost of health care to nation.⁷

Risk factors for the NCDs.



Tobacco use/ Alcohol consumption



Physical Inactivity/ Lack of exercise



Poor eating habits/ Unhealthy diet

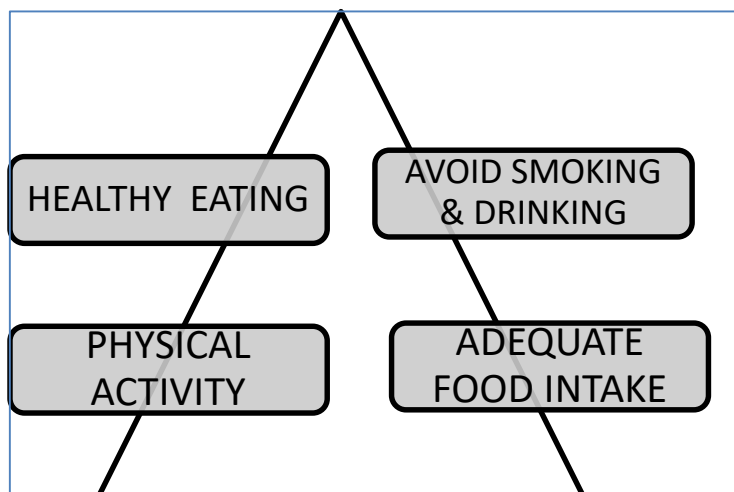
Managing the risk factors of NCDs

Behavioural risk factors such as smoking, alcohol consumption, inadequate physical activity and sedentary lifestyle, and unhealthy food can be managed by proper counselling of parents and adolescents.

Healthy habits are more likely to be followed when the whole family is ready for this change and choose healthy habits. Barriers towards healthy habits should be identified and managed.

It is important to identify genetic risk factors by identifying family history, which will enhance susceptibility. Such cases should be encouraged to adopt healthy diets, regular physical activity, and less (<2 hours per day) sedentary activities (screen time like television, videogames and mobile phones).

Smoking and other use of tobacco should be managed by counselling techniques.⁸



The overarching goal of the Global NCD Action Plan is to achieve the 2025 voluntary global targets.⁹



(Global status report on NCDs 2014)

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“A Travel through the IVF Revolution”

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“Motherhood contemplates as a crucial part in life of women; It's a touchstone by which the worth of women's is dignified. So infertility calls social stigma, with growing population, infertility is considered as a major health care issue among divergent communities. The high prevalence of this issue doubled its influence.

Incidence of infertility: Indian Society of Assisted Reproduction stated that “Infertility currently affects about 10 to 14 percent of the Indian population, with higher rates in urban areas where one out of six couples is impacted. It is time we recognize it as a perilous personal and public health issue.^{1,2}”

What is infertility? : Infertility is clarified as the incapacity to conceive after reasonable time of sexual intercourse without use of contraception. Regardless of high burdened individuals and couples, who wish but are unfit to conceive and maintain a desired pregnancy, require to fulfil their needs which are not being addressed, especially in lower class resource settings worldwide. couples and individuals, who desire but are unable to achieve and maintain a desired pregnancy, have needs which are not being addressed, particularly in lower resource settings worldwide.³

The development of in vitro fertilization: (IVF) revolutionized the management of female infertility as a significant tool, however, IVF fertilization rates remained poor in the presence of compromised semen parameters.⁴ Today, in vitro fertilization (IVF) is practically a household concept, but just before, it was a perplexed approach for infertility which is invented, thereafter, its well known as "test-tube babies." Louise Brown, born in England 1978, was the first such baby began life in a test tube outside her mother's womb. By 2100, In Vitro Fertilization (IVF) might account for 3.5% of the global population. It has already produced an estimated 6 million babies.⁵

Dr Robert G. Edwards and Dr Patrick Steptoe unfastened a new era in medicine when they successfully fertilized a human egg, which grew it briefly in a petri dish and transferred it into a woman's uterus to produce a fetus⁶. Soon after the birth of the first baby conceived through IVF, it was again Dr Edwards who observed that embryos that grow faster were more likely to result in a pregnancy. Afterwards “Controlled ovarian hyper stimulation” (COH) concepts came into existence to produce more than one egg per cycle.

Procedure of IVF: IVF is the process of fertilization by extracting eggs, retrieving a sperm sample, and then manually combining an egg and sperm in a laboratory dish. The embryo(s) is then transferred to the uterus.

Step1: Stimulation of eggs through hormone therapy: Fertility drugs are used to Stimulate the production of eggs. Normally, a woman produces one egg/month but fertility drugs allow the ovaries to generate several eggs which help in the procedure of IVF.

Step2: Retrieving the eggs from the ovaries: Egg is retrieved through a minor surgery called ‘follicular aspiration’ under the ultrasound imaging.

Step3: Fertilization of the eggs and sperm: The male sperm is combined together with the best quality of eggs. Eggs and sperm are then stored in an environmentally controlled chamber leading to fertilization.

Step4: Embryo culture: When the fertilized egg divides, it further develops into an embryo. Within a matter of 3-5 days, a normal embryo matures, which has several cells that are actively dividing.

Step 5: Embryo transfer: Embryos are placed into the woman's uterus 3 - 5 days after egg retrieval and fertilization.

Emerging trends In Vitro Fertilization: Various embryo selection technologies have emerged within the past decade, which includes Morphological assessment of the quality of pre-implantation embryos. The metabolomics techniques is helpful for pre implantation screening to determine the viability of embryo, it will be more cost effective and reduce the occurrence of pre term or premature birth.⁷ creating parents embryo with definite biogenetic disorders are one step closer to being enable healthful children via IVF, Creating three parents embryo, it's a controversial procedure that

involves creating an embryo using genetic material from parents, **Expanding the freezing of eggs and sperm** to cover the cost of female employees freezing their eggs for later use.^{8,9}

Currently couples are battling with the problem of rising infertility, which can be resolved by employing new and existing technologies. However, there is emerging evidence that IVF-conceived babies presumably at considerable risk of perinatal complications than naturally conceived babies and knowledge on long-term health effects of IVF is yet to know. Hence, all clinicians and researchers involved in the care of infertile couple must maintain a heightened awareness of these potential issues. Since IVF was pioneered by great researchers, it has helped millions of people become parents and build healthy families.

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**National Conference on
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Organized by

Sumandeep Nursing College (A Constituent of Sumandeep Vidyapeeth), Piparia, Vadodara, Gujarat, India

“Stem cells as a rising Archetype in stroke”

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The substitution, repair or renovation of injured tissues is concerned with multifaceted field termed as regenerative medicine. This area emerged from require for reconstruction in offspring and adults in whom tissue has been destructed by diseases, trauma and inherited anomalies. The stem cell research is hopeful field with an alluring probability for curative modalities.¹

Renewal of neurons has been a challenging task before fifty years. Thus, neurodegenerative disorders (e.g. Parkinson's disease, Alzheimer's disease, multiple sclerosis), vascular events (e.g. stroke) and traumatic diseases (e.g. Spinal cord injury) considered as fatal illness. After that, stem cell researches came up with the hope of replacement therapy. The thousands of experiments and clinical trials are going on current topic. As an outcome, cell replacement became a capable treating option for nervous system related disorders.²

Cerebrovascular accident which is also termed as Stroke is, “sudden development of cerebral function disturbances, with symptoms may lasts for 24 hours or extended period may cause death, with no evident cause other than of vascular origin”. Worldwide stroke is second leading cause of fatality in younger people and majority of people affected which are belongs to developing countries.³ The stroke rate in India is 145 and 154 per 1,00,000 per annum. The majority of stroke prevalence rate is taking place in India.⁴

In January 2019, at the University of Texas Health Science Center at Houston; the clinical trial was carried out on first U.S patient who was affected with stroke disability, participated in international study of stem cell. In which the stem cells were directly injected into the brain. The prime endpoint of the research is a comparison of the proportion of patients in the treated and placebo arms showing a clinically significant progress on the Modified Rankin Scale, a measure of disability and dependence, at six months post-treatment compared with baseline.⁵

The findings of a small clinical trial led by Stanford University School of Medicine investigators, suggested that injecting personalized, human, adult stem cells directly into the brains of chronic stroke patients proved not only secure but efficient in restoring motor function.⁶

Beginning of stem cell research for stroke:

The primitive study was carried out by using brain cell which were derived from tumor termed as teratocarcinoma. The findings shown that teratocarcinoma is useful to create neurons in laboratory. The researchers transplanted these neurons into the brain of affected rat and found out that the transplanted cells are able to replicate into the rat's brain. In 2000 a clinical trial was carried out on stroke patient. The derivation of these cells in a tumor, joined with lack of progress shown in patients has encouraged investigators to focus on other possible stem cell sources.⁷

CVA and Neural stem cell:

The neural cells are the basic cell of the brain. It is among the essential types of stem cell being experimented for treating stroke. After injecting the neural stem cell into the brain they travel to the damaged area for curing the stroke. These cells are enhancing healing by releasing substances that relieve inflammation and improve survival of existing neurons.⁷

Embryonic stem cell and iPS cell and CVA:

These cells having potential to replicate in large number. The first research by using theses cell was carried out in 2005. In 2006 a trial group from Germany found that these cells not only survive but make new cells in brain, but the

neurons they produced could also make connections to existing neurons of the brain. While 2008 and 2009 various studies finalized that transplanted neurons formed from human embryonic stem cells were able to combine into rat brains after an ischemic stroke. They noticed the improvement in movement of animal. Currently, a research done by Sweden and Germany reported alike results in mice and rats using neural stem cells made from human iPS cells.⁷

Mesenchymal stem cell and CVA:

MSCs obtained from the bone marrow and adipose tissue have been injected into the veins of lower extremities of rats which is affected with stroke. In these trial results projected that treated rats have decreased affected area while comparing with non treated rats. But more researches are indicated to comprehend fully that which mechanism of action is taking place while this procedure.⁷

CONCLUSION:

For advance and secure experimental healing for stroke the regenerative - cell based therapy is being accessed cautiously in the laboratory with meticulous clinically significant translational studies. To offer assistance and direction to this budding field, additional researches are advisable. However, like with all other brain disease, there is no strong evidence that which mechanism of action is taking place while using stem cell as stroke treatment. Moreover, few researches are giving evidence of revival rate after stroke. As there is no hasten for stem cell to reach that clinical development stage, only with the a extended period assurance to high feature basics and quantifiable research it will be probable to recommend stem cell based treatment providing patients with stroke with considerable improvement in their quality of life.

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“Quality of life of elderly in India: A Review”

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Introduction:

Aging is a progressive functional decline, or a gradual deterioration of physiological function with age, including a decrease in fecundity¹, or the intrinsic, inevitable, and irreversible age-related process of loss of viability and increase in vulnerability². Clearly, human aging is associated with a wide range of physiological changes that not only make us more susceptible to death but limit our normal functions and render us more susceptible to a number of diseases.³

The proportion of people aged over 60 years is rapidly increasing than any other age group because of increased life expectancy in almost every country in the world. This demographic change has various implications for public health, especially as older ages is a vulnerable factor for many chronic diseases and generally slow progression. Chronically ill older adults have complex patterns of health care, frequent hospital readmissions; often receive poor or uneven quality of care. Numerous leading organizations and experts argue that care coordination focussing wellness, prevention, and chronic disease management is a promising means to enhance the quality⁴

Magnitude of the problem:

By 2020, for the first time in history, the number of people aged 60 years and older will outnumber children younger than 5 years. By 2050, the world's population aged 60 years and older is expected to total 2 billion, up from 841 million today.⁵ The rapidly growing numbers of older peoples' population in both developed and developing countries mean that they all would be at risk of a challenge to their QOL. The challenge in the 21st century is to delay the onset of disability and ensure optimal QOL for older people.⁶ The WHO has recently notified the member countries that as people across the world live longer, soaring levels of chronic illness and diminished well-being are poised to become a major global public health challenge.⁵

With on-going improvement in health-care delivery services, life expectancy has improved and thus increases geriatric population. It has been estimated that the number of people aged 60 and over will increase to 1.2 billion in 2025 and two billion till 2050. Moreover, by the year 2025, almost 75% of this elderly population will be living in developing nations, which already have an overburdened health-care delivery system.⁷

India's population is likely to increase by 60 per cent between 2000 and 2050 but the number of elders, who have attained 60 years of age, will fire up by 360 per cent and the administration should start outlining policies now else its consequences are likely to take it by surprise. At present India has around 100 million elderly and the number is expected to increase to 323 million, constituting 20 per cent of the total population, by 2050.⁸

Quality of life:

Everyone has an opinion about their quality of life, but no one knows indeed what it means in general. It is renowned that individual opinion about well-being was 'the best means of knowledge immensely surpassing those that can be possessed by anyone else'.⁷ Hence, quality of life is highly individualistic and might even be an 'idiosyncratic mystery' due to the high levels of variability between individuals, making it unsuitable for decision making.⁹

World Health Organization defines Quality of Life as 'an individual's perception of life in the context of culture and value system in which he or she lives and in relation to his or her goals, expectations, standards, and concerns'. It is a broad concept covering the individual's physical health, mental state, and level of independence, social relationships, spiritual beliefs, and the environment. The quality of life can be weighed by assessing a person's subjective feelings of happiness or unhappiness about the various life concerns¹⁰.

Quality of life is the general well-being of individuals and societies, outlining deleterious and constructive features of life. It observes life satisfaction, including everything from physical health, family, education, employment, wealth, safety, and security to freedom, religious beliefs, and the environment.¹¹ QOL has a wide range of contexts, including the fields of international development, healthcare, politics and employment.

Quality of life in elderly:

Elderliness is a qualitatively different experience for each subject. It is preponderantly good for some, 'an autumn with deep but bright tonalities' and a bad experience for others. Between these two extremes of good and bad quality, there is probably a continuum.¹²

QOL has many dimensions such as material well-being, close relationships, health, emotional well-being, and productivity. QOL differs from individual to individual and is dependent on different factors. As the demographic pattern has changed with more elderly people, the overall QOL of a nation has also changed.¹³ Loneliness, social disconnection; poor physical and mental health status contribute to poor QOL of elderly.

Elderly people live with many physical as well as mental problems, and social detachment fades the condition. QOL of elderly people is closely associated with different socio-demographic factors. The triple evils of ill-health, loneliness, and social disconnection worsen the QOL of elderly.¹⁴

Studies assessing the Quality of Life of elderly in India:

To review the existing literature on quality of life of elderly in India, search was carried out using PubMed search engine with relevant search terms to identify the relevant related studies. Around 290 records identified, after the screening 12 articles (research papers) were fulfilled the inclusion criteria. (Table1).

Table No: 1 Specification of review articles about quality of life of elderly in India ^{15 – 26}

Author (s)	Title	Place	Type of study	Sample size	Finding on Quality of Life
Ghosh S, Bandyopadhyaya S, Bhattacharya S, Misra R ¹⁵ 2014	Quality of life of older people in an urban slum of India	Urban slum in India	Cross sectional study	120 Elderly	stumpy education, being single, deficient personal income, and not living with their children considerably reducing Quality of Life in elderly
Kumar S G, Majumdar A, G P. ¹⁶ 2014	Quality of Life and Its Associated Factors Using WHOQOL-BREF Among Elderly in Urban Pondicherry, India	Urban Pondicherry	Community based cross sectional study	300 elderly	QOL score among elderly is average, while social relationship domain of QOL was found low.
Joseph N, Nelliyanil M, Nayak SR, Agarwal V, Kumar A, Yadav H. ¹⁷ 2015	Assessment of morbidity pattern, quality of life and awareness of government facilities among elderly population in South India	Bangalore, Karnataka	Survey	206 elderly	Elderly with morbidities had poor QOL.
Ramadass S, Rai SK, Gupta SK, Kant S, Wadhwa S, Sood M, Sreenivas V. ¹⁸ 2018	Prevalence of disability and its association with sociodemographic factors and quality of life in a rural adult population of northern India.	Rural area of Ballabgarh, Haryana	Cross-sectional study	418 randomly selected Elderly	There was a high Prevalence of disability than the estimate given by Census 2011. As age rises, quality of life declines. Surge in the level of disability drops the quality of life.
Dongre AR, Deshmukh PR. ¹⁹ 2012	Social determinants of quality of elderly life in a rural setting of India.	Field practice area of a Rural Health Training Centre.	Community based mixed-methods	All the elderly of two feasibly selected wards of village Anji	Necessity for intervention at social and family level for elderly friendly environment at home and community level.

Samuel R, McLachlan CS, Mahadevan U, Isaac V. ²⁰ 2016	Cognitive impairment and reduced QOL among elderly in Southern Urban India: home-based community residents, free and paid old-age home residents.	Chennai, India	Community based cross-sectional study	173 elderly home-based community-dwellers, 176 paid-home and 150 free-home residents	There was high load of cognitive in all aged-care dwelling types in urban India; with free charitable home residents being worse affected. Cognitive impairment was associated with disability and poor health-related QOL in these age-care settings.
Dongre AR, Rajendran KP, Kumar S, Deshmukh PR ²¹ 2012	The effect of community-managed palliative care program on quality of life in the elderly in rural Tamil Nadu, India.	Villages of Tamil Nadu, India	Community -based evaluation study	450 elderly	In the project villages, the perceived physical quality of life and psychological support among elderly persons was significantly better than the control villages.
Lahariya C, Khandekar J, Pradhan SK. ²² 2012	A community based study of health related quality of life of the elderly in urban India.	Central Delhi, India	Cross-sectional study	200 elderly	In urban India the quality of life of elderly is severely affected by the disabilities, impairments and chronic morbidities. There is an instant need for definite preventive and rehabilitative measures targeted on elderly to maintain their quality of life in elderly population in Delhi.
Deshmukh PR, Dongre AR, Rajendran K, Kumar S ²³ 2015	Role of social, cultural and economic capitals in perceived quality of life among elderly in Kerala, India.	28 villages in Kollam district of Kerala	Cross-sectional study	900 old age people	It is noted that the policies for old people should envision retaining cultural and social norms along with the economic interventions for a better quality of life
Sowmiya KR, Nagarani ²⁴ 2012	Quality of Life of Elderly in Mettupalayam, A Rural Area of Tamilnadu	Rural areas of Mettupalayam, Tamilnadu	Descriptive cross sectional study	509 elderly	Study found that elderly had average QOL and had lowest score on physical domain
Praveen V, Rani AM ²⁵ 2016	Quality of life among elderly in a rural area	PHC at Nemam, Thiruvallur district, Tamilnadu	Community based cross sectional Study	50 elderly	QOL score among elderly was found to be average. The scores of social relationship were found low for both gender of elderly
Shah V R, Donald S, Arpit C, Prajapati, Patil MM and Sonaliya KN ²⁶ 2017	Quality of life among elderly population residing in urban field practice area of a tertiary care institute of Ahmedabad city, Gujarat	Ahmedabad, Gujarat	Community based cross sectional study	250 elderly	56% had good QOL and 44% had excellent grade of QOL

Strategies to improve Quality of Life of Elderly:

At present most of the tertiary care hospitals have geriatric outpatient department and geriatric ward for health care services to elderly population. Alongside, most of the day care centers, old age homes and counseling centers are urban based. Study on assessment of unmet needs of elderly in India highlights that majority of elderly (46%) were

unaware of the availability of any geriatric health care services near their residence and 96% had never used any geriatric welfare service²⁷.

Two third of elderly population lives in countryside, it is mandatory that geriatric health care services be made a part of the primary health care. In line with it requires a training of all healthcare professionals in relation to geriatric medicine/geriatric nursing/geriatric dentistry / geriatric physiotherapy etc. Similarly the grass hood level health care workers must be sensitized and educated to identify and refer elderly for sensible and correct treatment. It is also greatly beneficial to the elderly residing in remote rural and tribal areas, where the organization of mini and multi diagnostic camps or screening camps in collaboration with Non-Governmental Organizations or Voluntary Organizations (such as Help Age India) or use of mobile clinics to provide care at their door steps²⁸.

Make avail health care services based on the felt needs of elderly, where the needs of elderly are assessed through health screening and the felt needs vary based on their gender, socio economic status, cultural background and residence etc. It is the need of the hour and mandatory to focus on providing primary care and prevention strategies of major diseases. The core component of primary care is creation of awareness on age related changes, elderly diseases and the steps to prevention (nutrition, exercise, social engagement, use of leisure times etc). The elderly must be sensitized on legal protections by government of India various polices and welfare services offered by Government of India, and the benefits they will enjoy at public sectors such as railways, road transport, hospitals, bank sector etc²⁹. Alongside the changing mind set of elderly in positive manner with help of prayer, meditation, improving wellbeing should be included³⁰.

Capacity buildings for health care professionals, NGO's, family members, care givers on care of elderly is another valuable strategy for improving the QOL of elderly. The capacity building strategy have demonstrated a noteworthy success in a community based project on care of dementia/Alzheimer's patients wherein the health care workers render home care in day care centers³¹.

National Sample Survey envisage that the proportion of aged persons who cannot move and are confined to their bed or home ranges from 77 per 1000 in urban areas to 84 per 1000 in rural areas³². Enhancement of physical, psychological wellbeing and vocational skills of elderly is always uplifted through rehabilitation service. Rehabilitation services include supplementation of visual aids, hearing aids and mobility aids such as cane, walker, and stick etc; availability of physiotherapy and rehabilitation services; and imparting education about staying healthy and mobilized. ³³.

As a part of geriatric medicine, multi-disciplinary health care team specially trained to meet the needs and health problems of elderly. The team must comprise of physician, psychiatrist, dentition, dietitian, physiotherapist, nurses etc and the services must be offered in a reasonable price or if required free of cost. In this regard day care hospitals and hospice care centers offers valid and reliable services and follow up care for the elderly suffering with chronic illness³⁴. However in India there is a less number of day care centers and there is a need for increased number of centers at various districts across India in collaboration with NGO's and charitable organizations.

Research in the field of geriatrics and gerontology needs to be encouraged and further strengthened. The thrust areas of research on elderly are activity of daily living, functional status, quality of life, common chronic diseases, neurodegenerative diseases, alternative and complementary therapies etc. There is a need for adequate funds for conducting research on these focused areas to generate the evidence for enhancement of wellbeing and QOL of elderly³⁵.

Conclusion:

Ageing is an inevitable process, which brings a unique challenge for all sections of the society. Aging is a process of deterioration in the functional capacity of an individual that results from structural changes, with advancement of age.[Longevity must come along with the quality, then and then feeling of contentment could be achieved. To emphasize the medical and psychological difficulties faced by geriatric people is the need of current time.It's not enough to just be alive and Good quality of life and sense of wellbeing is especially important for older adults. Feeling satisfied and fulfilled is as important as getting regular checkups and screening from the health care professionals.

Having optimistic outlook towards life can help elderly have more energy, less stress, better appetite and prevent cognitive decline. Although this paper has focused on the quality of life of elderly and strategies for improving wellbeing and quality of life, it must be remembered that improving the quality of life of elderly needs a holistic approach and concerted efforts by the various stakeholders like government and health related sectors, family and care givers etc.

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(Enhancing Innovative and Futuristic Practice in Nursing)
4th & 5th, July - 2019**

Organized by
Sumandeep Nursing College (A Constituent of Sumandeep Vidyapeeth), Piparia, Vadodara, Gujarat, India

“Mentoring: Its not what we give but what we share”

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WHAT IS MENTORSHIP?

Mentorship is a one-on-one mutual, committed relationship between a mentor and mentees designed to promote personal and professional development beyond any particular curricular or institutional goal.

Mentorship is partnering with the younger generation or workforce to add value to the strong competencies they already possess. Prahlad Kakar adds, “Mentorship is a two-way process, you both learn and teach. In fact, mentors often learn more than they teach.”¹

An essential first step in a successful mentoring relationship is for both the mentor and mentee to identify, define, and honestly articulate their common and individual goals and motives. Mentors encourage mentees to develop to their fullest potential and to create their own vision for the future. A mentor is a guide, a listener, a coach and a friend to grow mentees’ internal talents by providing them with leadership challenges and developmental opportunities & also to enrich and support the professional, academic, and personal experiences of mentees in order to assist them in the transition from academic to professional life.

TIPS TO MAINTAIN MENTOR-MENTEE RELATIONSHIP :

- 1. Put the relationship before the mentorship:** All too often, mentorship can evolve into a “check the box” procedure instead of something authentic and relationship-based. All this is to say that mentoring requires rapport.
- 2. Focus on character rather than competency:** The best leaders go beyond competency, focusing on helping to shape other people’s character, values, self-awareness, empathy, and capacity for respect.
- 3. Shout loudly with your optimism, and keep quiet with your cynicism.** Your mentee might come to you with some off-the-wall ideas or seemingly unrealistic ambitions. You might be tempted to help them think more realistically, but mentors need to be givers of energy, not takers of it.
- 4. Be more loyal to your mentee than you are to your company:** Of course, we all want to retain our best and brightest. Don’t seek only to uncover your mentees’ strengths; look for their underlying passions, too.²
- 5. Journal your way to new conversations:** If you’re a mentor, keep a daily journal. Between now and your next session, write down challenges and successes you have each day. Don’t overthink: just jot things down as they occur. You’ll be surprised by the conversation topics that will come up.
- 6. Go with the flow:** At the same time, don’t worry if you no longer always have “topics” at hand. It’s become more of a true relationship rather than a partnership where the mentor and mentees are focusing on goals and objectives. When you meet, allow the conversation to happen organically. Talk about whatever is important until you come to the official ending.
- 7. Mix it up. Making a simple change:** The time you meet or the location, for example—can be enough to inspire new perspectives and re-energize participants.
- 8. Ask other mentoring pairs for suggestions:** Chances are if you’re part of a formal program, you’re aware of and/or know some other mentoring pairs. Compare notes regarding ideas.
- 9. Don’t mistake natural shifts for a lack of energy or interest:** Again, it’s easy to think that these changes indicate a problem, when, in reality, they simply show how the relationship is maturing—and that’s a good thing.³

MENTORSHIP IN NURSING

College can be an overwhelming place, especially for students just starting college, and the shift to a new life at school can trigger previously undetected mental health issues such as Depression, anxiety, or eating disorders. Studies show that 27 percent of college age kids experience some type of mental health problem. Anxiety disorders, social phobia, obsessive-compulsive disorder, panic disorder, and others are common in the college-age population. Cutting, burning and self-harm is a response to stress and pressure is common among students. Alcohol abuse, illegal drugs, and prescription drugs (such as ADHD medications) has been and continues to be a major college health issue

that contributes to accidents, sexual assaults, and high-risk sexual behavior on campus. These are the problems where a mentoring helps students to come out from the problems and cope up with the life's situation.⁴

Suicide is a most common act found among younger age because of having emotional issues. In recent years there were many cases of suicide among nurses found in Gujarat too. In April, 2018 one suicide case of nurse who served as a staff nurse at PHC of Suredranagar District was found.⁵ A nurse committed suicide because of harassment from medical doctor in Civil, Mehsana on Oct. 15, 2018. One famous case of Surat, Ms. Aruna Shanbaugh, who was sexually assaulted by ward boy, this case went till the supreme court and finally she died on 18th may, 2015⁶.

So its necessary to have some innovative practices in each organizations to come out from psychological and emotional issues. Nurses should be prepared to serve from the bedside to the board room, mentor others along the way, develop leadership competencies and take active role in Policy. There should be application of any types of mentoring in each organization. For ex: Induction mentoring, Peer mentoring, Developmental mentoring, Formal- Informal, Co mentoring, E-mentoring.⁷

ADVANTAGES OF MENTORSHIP IN NURSING

- Empowers Positive Choices
- Encourages ownership of Learning
- Strengthens interpersonal skills and peer relationships thus preventing isolation which could lead to disconnect/disengagement and burn-out from care provision.
- Empowers nurses with clinical information, organizational skills and confidence.
- Promotes a competent nursing practice by influencing the quality of care.⁸

CONCLUSION:

A time-honoured practice, mentoring is a fixture in schools and universities, workplaces, and religious communities, as well as in youth-development programs. Mentoring relationships sometimes form organically and informally, though they're often part of a structured program. The most successful mentorships are the ones that are a two-way experience where both sides benefit from the relationship," says Caine. "In these relationships, the mentor experiences satisfaction and new perspectives by providing guidance and insight to the person seeking advice, while the mentee gains the benefit of experienced advice.⁹

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“Work-Life Balance and Stress; An Overview”

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Work-life balance is the lack of opposition between work and other life roles. It is the of equilibrium in which demands of personal life, professional life, and family life are equal.¹ For successfully managing work–life balance, one of the essential factors is the ability to reduce and control stress. Stress is doubtless problems faced by the current workforce. It is also becoming an increasingly worrying problem for employers. Here, we review stress in the workplace, the current legal attitude, and what individuals and employers can do to minimize stress and its damaging consequences.¹

STRESS AND THE WORKPLACE

While some workplace stress is normal, excessive stress can interfere with your productivity and performance, impact your physical and emotional health, and have an effect on your relationship and personal life. It can even determine win or loss on the job. You cannot control everything in your work area, but that isn't mean you are helpless, even if you are stick in a tough condition. Whatever your goal, there are few steps that can take to protect yourself from the effects of stress, improve your job satisfaction, and strengthen your well-being in and out the work place.²

POSITIVE AND NEGATIVE STRESS

Stress is generally claimed as something negative, it is in reality also a positive driver. Positive stress can be experienced when someone is well focused on a particular task, motivation, feeling confident and excited about the result they hoping to achieve. This feelings can be short term feeling. Negative stress occurs when a person feels unable to perform or to cope with a situation. It is a typical short term feelings.³

We can further our understanding by breaking stress into its four most common types:

1. **Survival stress:** any event that can lead to stress and as everyone has experienced, events don't always come one at a time.⁴
2. **Internally generated stress:** Internal stress comes from inside of yours and determine your body's ability to react to, and deal with it.⁵
3. **Environmental and job stress:** Your living or working environment causes the stress. It may come from noise, crowding, pollution, untidiness, dirt or other distractions. Alternatively, stress can come from events and pressures at work.
4. **Fatigue and overwork:** Here stress builds up over a long period of time. This can occur where you try to achieve too much in too little time, or where you are not using effective time management strategies.

STRESS MANAGEMENT

Stress management is the ability to recognize the sources of stress and restructure yourself, your work or your life in order to cope with them. This is different from stress reduction which involves eliminating the sources of stress.

Stress management techniques:

1. **Change your thinking:**

- Re- framing
- Positive thinking

2. Change your behaviour

- Be assertive
- Get organised
- Ventilation
- Humour
- Diversion and distraction

3. Change your lifestyle:

- Diet
- Smoking & Alcohol
- Exercise
- Sleep
- Leisure
- Relaxation

Stressful situations can be categorized under the following four headings:

- Death in the family
- Losing your job
- Moving
- Having difficult conversation
- Being the victim of a crime
- Dealing with serious illness or injury
- Divorce
- Financial difficulties
- Legal issues⁶

STRESS AND THE EMPLOYER

An estimated 57% of all working days lost to ill-health are due to stress, depression or anxiety. Stress is the most common cause of long-term sickness absence and perhaps, unsurprisingly, employees point to high workloads, long hours and boss management style as the key triggers.⁷

WHAT ARE EMPLOYER'S OBLIGATION TO MANAGE STRESS

Health and safety legislation obliges you as an employer to assess the risk of stress and take steps to reduce it.⁷

EMPLOYER'S DUTY OF CARE

You should ensure that they actively manage absence, whether it is one day here or there or long term. Ensuring an open culture in which employees feel supported will help to demonstrate that as an employer you have taken the steps you need to take. Some simple adjustments to the employees work might relieve the stress, ex. Adjusting working hours or the delegation of certain duties. If a particular issue is identified, occupational health involvement might be required.⁷

ROLE OF NURSE :

Differentiate between job and home when you go home from working area leave your worries behind. After you get back home spend time with family, watch TV listen to music or do anything you like but don't think about office. Set a worry time

OTHER TECHNIQUE : Going for massage, indulging in your favorite hobby, talking about your problems to some one close to you.

Nurses interact with depressed, anxious and stressed-out patients on a daily basis. Nurses who work specifically with mentally challenged patients develop skills to deal effectively with the behaviors and feelings of clinically anxious patients. Nurses throughout the healthcare system, however, are not always prepared to handle the emotional challenges many patients undergo. How a nurse reacts to patients' stress can have an enormous effect on their general well-being.

AS A MANAGER

- Adequate staffing
- Reduction of work load
- Appointing nurse specialist in ICU, CCU Critical care unit etc.
- Arrange in service education
- Skill training

- Provide time to take brake
- Arrange for picnic
- Provide basic facilities
- Arrange yoga and likewise
- Physical Exercise
- Emotional support to the staff in new position and new geographic area

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“Biliblanket Therapy: Treat to neonatal Jaundice & Guidelines for usage”

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ABOUT BILIBLANKET:

In order to completely understand what biliblanket therapy is used for, it is important to be aware of what causes a need for biliblanket. When a baby is born, there is a chance that baby may develop hyperbilirubinemia (neonatal jaundice) where there is excessive amounts of bilirubin in the blood. Thus biliblanket therapy is used to treat neonatal jaundice

A Biliblanket is medical device which can be carried easily used to treat hyper bilirubinemia or neonatal jaundice continuously at home or hospital. The biliblanket is a long pad that shines a full spectrum fiber-optic light which will not burn or harm baby's skin. The name Biliblanket originated as the trademark term of a General Electric product but has since been adopted as the colloquial term for this type of equipment.^{1,2} Biliblanket means bilirubin and blanket, other names used are home phototherapy system, bilirubin blanket, or phototherapy blanket.³ While baby placed in biliblanket, blood can be withdrawn and tested to check bilirubin levels, if it reached normal, then biliblanket therapy is not required. Even with this convenient form of phototherapy, child can be diapered, clothed, held, and nursed during biliblanket therapy.⁴

A randomized clinical trial was conducted by Romagnoli C, et. al., among 140 preterm infants, eligible infants were randomly assigned into four study group such as conventional, fiberoptic Wallaby, fiberoptic Biliblanket, and combined phototherapy, found that fiberoptic phototherapy, both Wallaby and Biliblanket, had the same effectiveness of conventional phototherapy and obtained best results by using combined phototherapy. Hence suggested that combined phototherapy should be good choice in treating hyperbilirubinemia in very preterm infants.⁵

PARTS OF BILIBLANKET:



DURATION FOR USING BILIBLANKET:

The duration of time for phototherapy treatment varies from one baby to the other as each baby's condition is different. However, health care provider will prescribe the duration of time for biliblanket therapy each day. Biliblanket can be used for 24/7 to provide continuous treatment if and only advised by doctor.

Most of the babies undergo phototherapy treatment for several days. Baby's bilirubin level can be tested during treatment, usually by a small sample of blood taken from the heel. These tests will determine when normal levels of bilirubin are reached and phototherapy is no longer needed.⁴

INSTRUCTIONS TO USE BIBIBLANKET:

1. Fix the fibre optic cable (tubing) to the machine by inserting it into the circular opening and then twist so that it remains securely in place. Attach power cord to machine.
2. Cover the pad with disposable cloth. Place the white side of the cloth onto the clear side of the pad.
3. Place the baby in supine position where, skin of the baby's back onto the white side of the covered pad and do not place the head on the pad.
4. Wrap the flaps with an adhesive around the baby's chest to secure in place or tucking flaps beneath the pad.
5. Wrap a blanket tightly around baby, keeping the Biliblanket directly against baby's skin. The blanket should be kept you from seeing the light of the Biliblanket. The baby may also lie skin to skin on mothers/caretaker lap with the Biliblanket over the baby's back. But be sure to cover both mother and baby with a blanket to keep the light away from eyes.
6. Plug the unit in and turn it on.
7. Whenever changing diapers or bathing, feeding, remove the biliblanket from the baby. However, the biliblanket should remain on as much as possible throughout the day and night. This will help in fast recovery from hyperbilirubinemia.²

DO'S AND DONT'S WHILE USING BIBIBLANKET:

Do's:

1. Make sure the light source box is on a flat hard non-absorbent surface such as table, nightstand or changing table surface. The baby's crib or carpet is probably not a good place.
2. Be sure baby's skin is in direct contact with the light pad. Diapers should be worn.
3. Use disposable light pad cover and cover the pad by clothing.
4. Keep the light pad on when holding or feeding baby.
5. Turn off light and remove the light pad when bathing baby.
6. Immediately change the disposable cover if it becomes wet or soiled.
7. Use a 3-prong plug for safety.
8. Set the intensity knob to the highest level on the light box.

Don'ts:

1. Do not use the light pad without a covering with cloth.
2. Avoid exposure of baby's eyes directly to the covered light pad.
3. Never place the pad on baby's head.
4. Do not keep anything on top of light source box and fiber optic cable.⁶

CONCLUSION:

In a nutshell, the biliblanket therapy is portable device used to treat hyperbilirubinemia which can be easily carried and convenient to use at home or in hospital. Moreover during this therapy baby can be reared, cared, nursed, diapered so that baby and their parents feel comfort. Nurses need to give clear instructions regarding the use of biliblanket at their home.

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**“NEURO-LINGUISTIC PROGRAMMING:
A toolkit of Methods for dealing with lifes, opportunities and Challenges”**

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Neuro-Linguistic Programming is a collection of a wide range of methods and models which creates an understanding of thought process and human behavior. Understanding these techniques can bring about a positive change in both yourself and those whom you share these ideas with. NLP had important life itself, would be accepted in serious scientific vehicles that deal with cognition. This theory is based on references cited only within their own tables without basing on the large amount of rigorous scientific material that is available in the Cognitive Science traditional, on behaviourism, in Cognitive Neuroscience, etc. NLP is modelling approach that offers a toolkit of methods for dealing with life's opportunities & challenges.

NLP is often referred to as a 'user's manual for your brain' and studying this life science can give us insights into how our thinking patterns affect every aspect of our lives. NLP looks at the way in which we think and processes our thoughts (Neuro), the language patterns we use (Linguistic) and our behaviors (Programming) and how these interact to have a positive (or negative) effect on us as individuals. Individual body senses are responsible to transferring all information to mind.

HISTORY OF NLP :

NLP was originally developed by Richard Bandler and John Grinder in the 1970's when the two met at Santa Cruz University in California. Bandler's background was in Mathematics and Gestalt Therapy and Grinder was a professor in Linguistics.

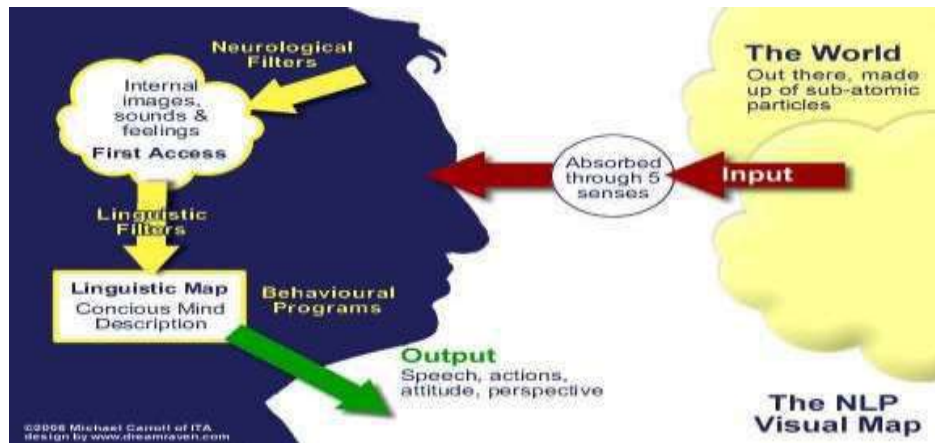
Over time, models were added from the world of behavioral psychology and linguistics and assuming the human brain like is working as a computer and what hacking the computer, it is virus same as the negative thoughts are virus which coming in brain and what evolved was an extensive toolbox of techniques and strategies that assist people in creating rapid change in thinking, learning and behavior.

FUNCTIONING OF NLP :

NLP might appear like magic or hypnosis. During therapy the subject goes deep into their unconscious mind and sifts through layers and layers of beliefs and perceptions to become aware of an experience in early childhood that is responsible for a behavior pattern. NLP works on the principle that everyone has all the resources they need to make positive changes in their own life. NLP techniques are used as a tool to facilitate these changes. NLP Therapy can be content free. That means the therapist can be effective without knowing about the problem in great detail. Hence the therapist need not be told about the event or even the issue, thereby ensuring privacy for the client. Besides this we also have a non-disclosure agreement in which the interaction between the client and the therapist is kept confidential.

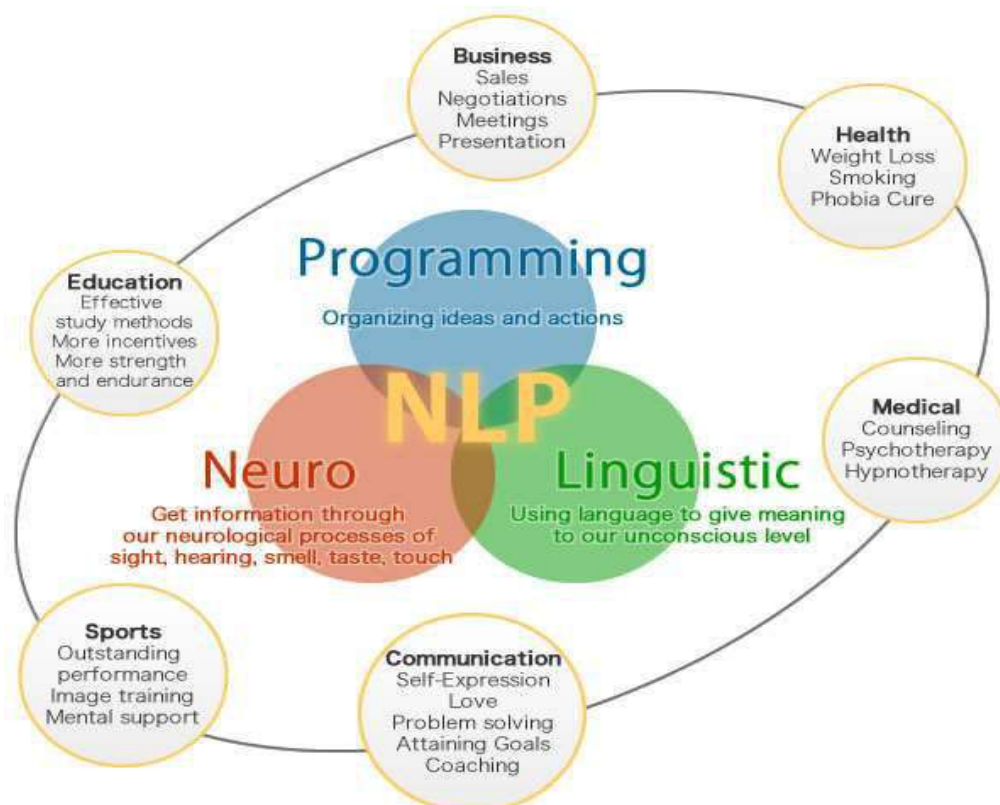
Every millisecond of life is recorded. Every laugh, every tear, everything we've seen, heard, and felt is held inside this massive database within our minds. Your mind knows your body, and has been storing information since you were a child in order to build a blueprint of perfect health in order to protect you and keep you alive. You may not realize it, but every day your unconscious mind stops you from hurting yourself without you even realizing.

In order to really explain how NLP works, for example, little bit about how the unconscious mind works.



APPLICATIONS OF NLP:-

- Help with relationship and marriage trouble
- Changing likes and dislikes and dislikes to like, popular for food habits
- Rectify unwanted behaviours in yourself and others
- Develop depth in personal and business relationships
- Improving sale and customer service in business
- Improving relationship with money
- Assisting with weight loss
- Relieving physical symptoms such as skin problems
- Increase your subconscious and sensory awareness



Among students:-

- Changing habits
- Alleviate fears and phobias
- Curing addictions including smoking
- Improve confidence and self esteem
- Conflict resolution
- Help with insomnia
- Developing leadership skills

- h) Removing stress
- i) Anxiety
- j) Depression
- k) Exam stress
- l) Spelling trouble
- m) Self-control from frustrations or other emotions.

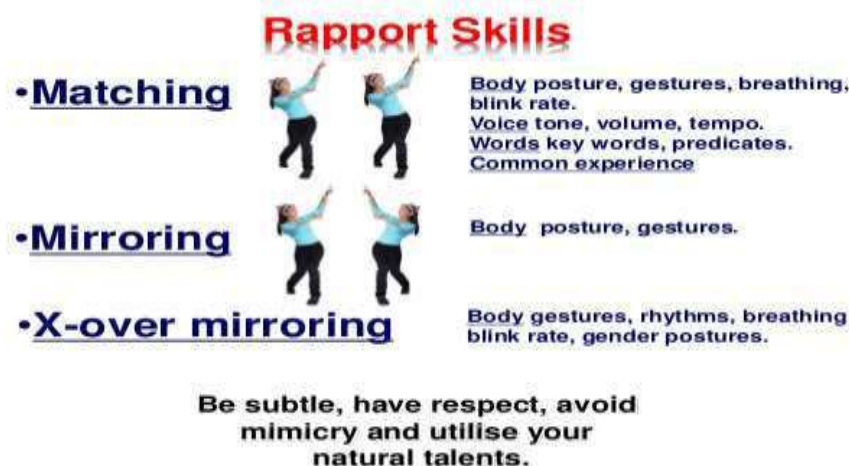
METHODS OF NLP :

“The NLP methods that were discovered can be powerfully effective in changing how a person can experience the world. Since person’s thoughts and feelings shape his reality, this means that these NLP methods can actually transform individual’s entire life. Here are five of the most impactful NLP methods when it comes to changing individual’s behavior and helping to manifest a better future.”

1. Getting Other People to Like You (Rapport):

“This is an easy set of NLP techniques, but they have the power to help you get along with virtually anyone. There are lots of ways to build rapport with another person. One of the quickest and effective ways comes from NLP. This technique involves subtly mirroring another person’s body language, tone of voice, and words. People like people who are like themselves. By subtly mirroring the other person, the brain fires off “mirror neurons,” pleasure sensors in the brain, which make people, feel a sense of liking for anyone mirroring them.

The technique is simple: Stand or sit the way the other person is sitting. Tilt your head the same way. Smile when they smile. Mirror their facial expression. Cross your legs when they cross theirs. Mirror their voice, etc. The key to creating an unconscious rapport is subtlety. If you are too overt, the other person may notice consciously, which would most likely break rapport. So keep your mirroring natural and calm.”



2. Dissociation:-“Much of the stress, depression and negative emotions we experience in day-to-day life are the result of trigger reactions to common experiences. Dissociation essentially severs the link between the negative state of mind and the trigger event. As such it is a very effective long term treatment for deeply entrenched psychological issues such as anxiety, depression, stress and phobias. It is also a positive way of dealing with difficulties at work, home or in our relationships.”

3. Content reframe:-Try this technique when you feel that a situation is negative or helpless. Reframing will take any negative situation and empower you by changing the meaning of the experience into something positive.



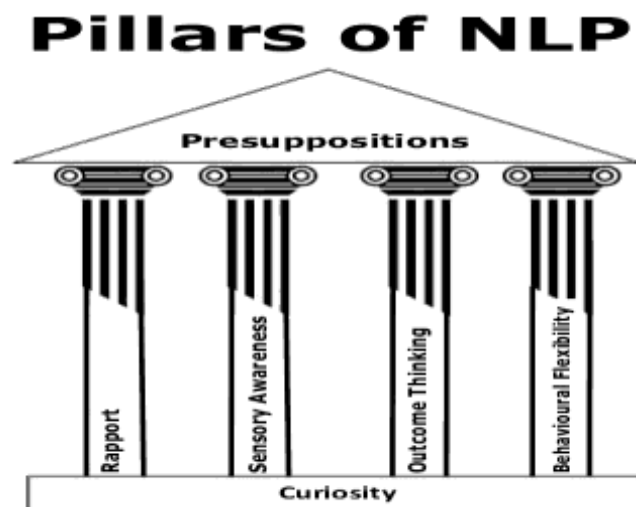
4. Anchoring:-Anchoring aims to elicit a habitual, positive emotional response to a specific word or physical stimulus.

5. Belief Change:-Childhood onward we gather around ourselves a complex web of beliefs, assumptions and opinions that guide and affect our everyday lives. “Many of these are so deeply ingrained that we spend most of our conscious time being completely unaware of them. Some of these beliefs are inherited from the society in which we were formed and others are of our own idiosyncratic creation. We are often unaware of some of these core beliefs until we find them challenged, when we often fly into an otherwise inexplicable defensive rage.”

PILLARS OF NLP:-

Followings are the four pillars (foundations) of the neuro-linguistic programming,

- **Rapport :-**NLP provides an important gift to build relationships with other people. Rapport can be described as connecting quickly with others. Creating rapport creates trust from others. Rapport can be built quickly through understanding modality preferences, eye accessing cues and predicates.



- **Sensory Awareness:** - Sometimes when you walk into someone's home, you notice that the colours, smells, and sounds are subtly quite different from yours. Neuro-linguistic programming enables you to notice that your world is much richer when you deliberately pay attention to your senses wholly.
- **Outcome Thinking:** - An outcome is your goal for doing something. Outcome connects to thinking about what you want, as opposed to getting stuck in a negative mode of thinking. The principles of outcome approach may help to make the best decisions and choices.
- **Behavioural Flexibility:** - Behavioural flexibility means being able to do something differently if the way you're currently doing it isn't working. Being flexible is a key aspect of practicing NLP. Learning NLP helps you to find fresh perspectives and to build these habits into your repertoire.

ADVANTAGES OF NLP:-

- a) Create more of the positive results that you want in your life.
- b) Identify the source of unhelpful (and disruptive) emotions.
- c) Change limiting beliefs to more useful and empowering ones.
- d) Envisage the life changes you want and set more effective goals.
- e) Become aware of the main building blocks of thought and experience.
- f) Leverage from Neuro-Linguistic Programming to improve your relationships.
- g) Communicate with more confidence and connect more meaningfully with others.

DISADVANTAGES OF NLP:-

- a) Only works where there is intention
- b) You have to put in work - If you're hoping to just lay back and not do a lot during your session, this is unlikely to be the solution. You have to *want* to change and so you'll have to put in the effort to do so.
- c) You may have some preparation to do before your session
- d) You just want to open your heart up and talk to someone for a long time
- e) It's a larger investment for one session compared to other therapies

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“Systematic Review and Meta-Analyses: A guide for evidence based Nursing practice”

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Abstract:

Systematic review and meta-analysis always targets to provide comprehensive, unbiased synthesis of various relevant studies in a single document using rigorous scrutiny. Systematic review differs from old-style narrative reviews in many ways. Narrative reviews tend to be descriptive; it is not involved in a systematic search of literature. Systematic reviews, as the name suggests, typically involve a detailed and complete plan and search strategies with the intention of reducing bias by identifying, appraising and synthesizing all the relevant research studies on a particular topic. Often, systematic review includes meta-analysis element which involves using statistical methods to synthesize the data from various studies into a single quantitative form. Although systematic review are published in academic forum, but there are some organizations and databases specially developed to promote and publish them. For example, Cochrane collaboration is widely accepted and recognized in health care field.

Key words: Systematic reviews, Synthesis, Quantitative, Meta-analysis & Cochrane.

INTRODUCTION:

This article is specially designed for Nurse Researchers and other health care professionals who are interested to perform systematic review and Meta-analysis. Following information covers effective formulation of answerable review question, determine inclusion and exclusion criteria, search for research evidences, extract data, assess and evaluate the risk of bias in clinical trials and perform meta-analysis.

FORMULATE THE REVIEW QUESTION

The first phase in performing systematic review is to formulate research question. Without a well-focused research question, it will be very challenging and time consuming to find appropriate resources and search for relevant literature evidence.¹

To prepare a well-built clinical question, Question must be directly relevant to the problem, Subsequently, the question must be phrased to facilitate search for a precise answer. To achieve these goals, the question must be well articulated for all four parts of its ANATOMY²

- 1) Patient or Problem being addressed
- 2) Intervention or Exposure being used
- 3) Comparison Intervention or Exposure
- 4) Clinical outcome of interest.

For Eg: For Clinical Situation we began with, Following questions must be asked: “Is animal assisted therapy more effective than Music therapy in Managing aggressive behavior in elderly people with Dementia?”³

Here, **P**- Elderly Patients with Dementia, **I**- Animal-assisted therapy, **C**- Music Therapy and **O**-Aggressive behavior When we forming question using the **PICO** framework it is very useful to think on what type of question you are asking (Diagnosis, Etiology, Diagnosis, Prognosis & Prevention). The table given below illustrates way in which Problem, Intervention, Comparisons and Outcome will vary according to the type your review question.⁴

Question Type	P	I	C	O
	Patient, Problem or Population	Intervention or Exposure	Comparison or Control	Example Outcome Measures
Therapy (Treatment)	Patient's disease or condition.	A therapeutic measure, e.g., medication, surgical intervention, or life style change.	Standard care, another intervention, or a placebo.	Mortality rate, number of days off work, pain, disability.
Prevention	Patient's risk factors and general health condition.	A preventive measure, e.g., A lifestyle change or medication.	Another preventative measure OR maybe not applicable.	Mortality rate, number of days off work, disease incidence.
Diagnosis	Specific disease or condition.	A diagnostic test or procedure.	Current "reference standard" or "gold standard" test for that disease or condition.	Measures of the test utility, i.e. sensitivity, specificity, odds ratio.
Prognosis (Forecast)	Duration and severity of main prognostic factor or clinical problem.	Usually time or "watchful waiting".	Usually not applicable.	Survival rates, mortality rates, rates of disease progression.
Etiology (Causation)	Patient's risk factors, current health disorders, or general health condition.	The intervention or exposure of interest. Includes an indication of the strength/dose of the risk factor and the duration of the exposure.	Usually not applicable.	Survival rates, mortality rates, rates of disease progression.

A well formulated question will helps to determine your Inclusive and Exclusive criteria, creation of search strategy, collecting data and presentation of your results.

DEFINE INCLUSION AND EXCLUSION CRITERIA

Once you have developed your research question, you will need to determine your inclusion/exclusion criteria - these are the characteristics which make a study eligible or ineligible to be included in your review. One of the features that differentiate the systematic review and traditional narrative review is the Pre-specification of eligible criteria (Including and Excluding the studies in review)

A large number of abstracts will found at the searching stage of review. Potential studies for the systematic reviews are scrutinized for the eligibility on the basis of its relevance and acceptability.

Systematic review seeks: Is the study relevant and acceptable for review? All systematic reviewers formulate inclusion and exclusion criteria to answer the review question further each systematic review has own purpose therefore its inclusion and exclusion criteria are unique in nature. However, criteria typically belongs to one or more categories such as study population, Nature of intervention, outcome, time duration, Culture and language range, type of research design and Publication date.^(5,6)

Each study need to compare against the same inclusion and exclusion criteria and can be included in review.

DEVELOP SEARCH STRATEGIES AND LOCATE STUDIES

A proper use of database and search filters allow you to narrow your results hence, researcher can retrieve the articles that are most appropriate and relevant to the research question. Filter options are vary by database that include Article publication dates, language, age, sex, species and subject.

In a systematic review search, reviewer should take care when applying filters, as researcher may lose the articles. The significant in developing an ideal search strategy is to balance the sensitivity that is retrieving a high proportion of relevant studies and receiving lower proportion of irreverent studies.⁸

SELECT STUDIES

Once after retrieving the comprehensive list of abstract, reviewer must filter the studies on the basis of inclusion criteria. The process of review is usually done by at least two reviewers to establish inter-rater reliability.⁹ The researcher team must agree on inclusion and exclusion criteria for the articles you are interested to review. Selection of studies takes place under following guidelines

- Screen each potentially useful study by reading title of the study and apply your inclusion and exclusion criteria.
- Decide whether to include the study in the review.
- Record the decision and reason for inclusion/ exclusion of the study screening.¹⁰

EXTRACT DATA

Once after identifying the studies to be included in systematic review, Next step is to extract and analyze the data presented on that studies.¹¹

In case of small number of studies were included, were reviewer probably don't need to go for coding the data for computer analysis instead summarize the information from the data extracted from selected studies. If a reviewer conducts an analytical review meta-analysis to compare the data from several studies, reviewer has to computerize the data. Data extraction by at least two reviewers is always important again for establishing inter-rater reliability and to avoid errors.¹²

Elements of data extraction:

- Consider the review question and objective
- Consider inclusion and exclusion criteria
- Consider the study Characteristics: Such as Full citation, objectives, intervention, Location, Duration, Design and methodology, outcome measures and results.¹³

ASSESS THE QUALITY OF STUDIES

There are many tools available in recent years to assess the quality of each RCT included in systematic reviews

Quality assessment elements

- Clinical question clearly stated?
- Search methods used to identify relevant studies clearly described?
- Was a comprehensive literature search performed?
- Are the inclusion/exclusion criteria used to screen primary studies clearly described?
- Was there duplicate study selection and data extraction?
- Were the characteristics of the included studies provided?
- Was the scientific quality of the included studies assessed and documented?
- Were the methods used to combine the findings of studies appropriate?
- Was the scientific quality of the included studies used appropriately in formulating conclusions?
- Was publication bias assessed?
- Was the conflict of interest stated?
- Are the stated conclusions supported by the data presented?

Rate the overall quality of the SR as "Good," "Fair," or "Poor" using questions.¹⁴

There are other more comprehensive recommended guidelines and standards available such as the Consolidated Standards of Reporting Trials (CONSORT Statement), as well as articles providing recommendations for improving quality in RCTs and meta-analyses for psychological interventions.

ANALYSIS AND INTERPRET RESULTS:

There are numerous statistical programme available to calculate the effects sizes for meta-analysis, Such as review manager endorsed by Cochrane collaboration. Effect sizes of meta-analysis are stated along with 95% confidence interval, and presented in both quantitative and graphical form (e.g. Forest plots).

Forest plots visually depict every trial as a horizontal diamond shape with the middle representing the study effect size and end point represent the zero mark. Often the left side of the graph represents the side favoring to the treatment and right side represent favor to the control condition. Bottom of the graph is summarize effect size or diamond represent all of the individual studies pooled together. Preferably, we would like to see entire diamond falling below zero indicate that intervention is favored over the control. The last step in writing processes summarizing the findings, and providing recommendations for clinical work. (e.g, Interventions are effective, for whom and under what condition) and research(e.g, Intervention required further research)⁹

CONCLUSION:

Article caters all the researchers and health care profession also carry out systematic review and meta-analysis effectively and thus helps to implement Evidence based practice appropriately.

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Sumandeep Nursing College (A constituent of Sumandeep Vidyapeeth), Piparia, Vadodara, Gujarat, India

**“A Study to Assess the Knowledge and Practice Regarding Healthy Eating
Among Adolescents in Selected Schools of Vadodara.”**

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Abstract:

BACKGROUND: Adolescence is the period when a child's body changes into that of an adult. Among other things, an adolescent has increased nutrient needs. Also a period where they may start dieting or skipping meals. Peer pressure can affect their eating behaviour and result in either over eating or under eating. **METHOD:** A quantitative research approach with non- experimental research design with non-probability purposive sampling to collect the 120 samples. A structured questionnaire and Practice checklist was prepared to assess the knowledge and practice of higher secondary school students. **RESULT:** The findings shows that association between factors contributing to the assessment of Healthy Eating habits among adolescents for the pre-test means score of knowledge of adolescents regarding healthy Eating habits is 14.38(55.52%). The pre-test mean score of practice is about 98 (81.67%) having good practice. The level of knowledge regarding Healthy eating among adolescents was about 66.66% knowledge regarding nutrition, 62.59% knowledge regarding nutrients, 49.31% knowledge of deficiencies and disorders. The level of knowledge regarding Healthy eating among adolescents. It was observed that among 120 participants, there was about 9 (7.5%) had poor knowledge, 55 (45.83%) having average knowledge and 56 (46.67%) having good knowledge regarding Healthy Eating Habits. **CONCLUSION:** This study was undertaken to assess the frequency and percentage distribution of knowledge and practice regarding Healthy Eating among adolescents in selected Higher secondary school students of Vadodara. The level of knowledge and practice were found good overall regarding the healthy eating habits from the sample. There were no association between the knowledge with the demographic variables found.

Key Words: Healthy Eating, Knowledge, Practice, Higher secondary school students.

INTRODUCTION:

Adolescence is the period when a child's body changes into that of an adult. Among other things, an adolescent has increased nutrient needs. Also a period where they may start dieting or skipping meals. Peer pressure can affect their eating behaviour and result in either over eating or under eating.

Healthy eating during adolescence is important as body changes during this time affect an individual's nutritional and dietary needs. Adolescents are becoming more independent and making many food decisions on their own. Many adolescents experience a growth spurt and an increase in appetite and need healthy foods to meet their growth needs. Adolescents tend to eat more meals away from home than younger children. They are also heavily influenced by their peers. Meal convenience is important to many adolescents and they may be eating too much of the wrong types of food, like soft drinks, fast-food, or processed foods. Also, a common concern of many adolescents is dieting. Girls may feel pressure from peers to be thin and to limit what they eat. Both boys and girls may diet to "make weight" for a particular sporting or social event.¹

Parents are encouraged to provide recommended serving sizes for children. Parents are encouraged to limit children's video, television watching, and computer use to less than 2 hours daily and replace the sedentary activities with activities that require more movement. Children and adolescents need at least 60 minutes of moderate to vigorous physical activity on most days for maintenance of good health and fitness and for healthy weight during growth. To prevent dehydration, encourage children to drink fluid regularly during physical activity and drink several glasses of water or other fluid after the physical activity is completed.

Adolescence is a time of newly discovered independence and freedom of choice. This puts adolescents in a group susceptible to external influences, particularly from the media, school and their peers. Adolescents experience periods of rapid growth associated with hormonal, cognitive and emotional changes. These are often confounded by lifestyle changes, such as leaving home, changing schools or starting work. Healthy eating during adolescence is an extension of healthy eating during childhood but often in an environment that relies on snacking and irregular meal patterns.²

LITERATURE REVIEW:

Sara J Martin A, Booth JN (2015) et. al conducted a study on considerable evidence linking physical activity, diet and other interventions for improving cognition and school achievement in children and adolescent with obesity or overweight. The global prevalence of childhood and adolescent obesity is high. Lifestyle changes towards a healthy diet, increased physical activity and reduced sedentary activities are recommended to prevent and treat obesity. Evidence suggests that changing these health behaviours can benefit cognitive function and school achievement in children and adolescents in general. There are various theoretical mechanisms that suggest that children and adolescents with excessive body fat may benefit particularly from these interventions.³

Green SH, (2015) et. al conducted a study on considerable evidence linking changes in school competitive food environment after a health promotion campaign. Schools can reduce student access to competitive foods and influence healthy food choices by improving the school nutrition environment.→ This study describes changes in competitive nutrition environments in 100 K-8 schools participating in the Philadelphia Campaign for Healthier Schools.⁴

Haidar A (2015) et. al conducted a research on The study aimed to examine nutrition label use and dietary behaviours among ethnically diverse middle- and high-school students, in Texas, USA. The School Physical Activity and Nutrition (SPAN) survey is a cross-sectional state wide study using a self-administered questionnaire to assess nutrition and physical activity behaviours. Height and weight measurements were used to determine BMI. Multivariable logistic regression was used to determine associations between nutrition label use and dietary behaviours, with gender, grade, ethnicity, BMI, parent education, socio-economic status and nutrition knowledge as covariates. Participants from 283 schools, weighted to represent Texas youth. SPAN 2009-2011 included 6716 8th and 11th graders (3465 girls and 3251 boys). The study population consisted of 39.83 % White/Other, 14.61 % African-American and 45.56 % Hispanic adolescents; with a mean age of 14.9 years, and 61.95 % at a healthy weight, 15.71 % having overweight and 22.34 % having obesity. Adolescents who did not use nutrition labels had 1.69 times greater odds of consuming ≥ 1 sugary beverages/d ($P < 0.05$). Adolescents who used nutrition labels had 2.13 times greater odds of consuming ≥ 1 fruits and vegetables/d ($P < 0.05$). Adolescents who used nutrition labels had significantly higher healthy eating scores than those who did not ($P < 0.001$). For every 1-point increase in nutrition knowledge, adolescents had 1.22 greater odds of using nutrition labels. Nutrition label use is associated with healthier dietary behaviours in adolescents. Intervention strategies for youth should include efforts to teach adolescents to use labels to make healthy food choices.⁵

STUDY OBJECTIVES:

- Assess the level of knowledge of adolescents regarding healthy eating
- Assess the practice of adolescence regarding Healthy eating
- Find the correlate and associate the knowledge and practice

MATERIALS:

Research design

In this study, the research design was non experimental research design.

Setting

Higher secondary Students from Jeevan Sadhna school and Vidyakunj school, vadodara

Sample

120 students from Sumandeep Nursing College

Inclusion criteria

- Higher secondary school children with age group between 16 to 18
- Higher Secondary school students who are willing to participate.
- Higher Secondary school students present during the time of data collection.

METHOD:

Description Of Tools

Section 1:

Consists of demographic variables such as Age, Gender, Religion, Stream of study, Grade, Type of Family and Area of Living.

Section 2:

Multiple Choice Questions Of Different Topics Respectively. 25 Multiple Choice Questions Where The Correct Answer Will Be Given 1 Mark And Wrong Answer Will Be Given 0 Marks.

Section 3:

Checklist consist of 16 items Self Structure questionnaire.

Scoring Criteria as follows:

Poor: - 1 - 5

Average :- 6 - 10

Good: - 11 – 16

Reliability

The reliability of tool established by using split half method Spearman Brown Prophecy formula ($r=0.75$) reliability test.

Data collection procedure

A formal permission will be obtained from the concerned authority. The data collection will be done within given period of time of one week. After a brief introduction of the self and establishing the rapport, the investigator will give brief details about the nature of the study and an oral consent will be obtained from the sample and confidentiality of the responses to be assured. Samples from 2 schools of Vadodara namely; Vidyakunj and Jeevan Sadhna. The higher secondary students were selected for the purpose of data collection.

Statistical design

Data were verified prior to computerized entry. The Statistical method was used. Descriptive statistics were applied (e.g., mean, standard deviation, frequency and percentages). Test of significance (chi square and paired t test) was applied to test the study hypothesis.

FINDINGS

Section A: Analysis of Demographic variables.

The demographic variable show the frequency and percentage distribution of students based on their grade. It was observed that among 120 participants 108 (90%) belonged to 11th grade, and 12 (10%) students belong to the 12th grade, the frequency and distribution of students or participants based on their Gender. It was observed that among 120 participants 76 (63.33%) are male and 44 (36.66%) are females, the frequency and distribution of participants based on their stream of study. It was observed that among 120 participants 63 (52.5%) belong to the science stream and 57 (47.5%) belong to commerce stream, shows the frequency and percentage distribution of participants based on their religion. It was observed that out of 120 participants, 109 (90.83%) belong to Hindu religion, 8 (6.66%) belong to Muslim religion and 3 (2.55%) belong to other communities, the frequency and distribution of students based on their course of study. It was observed that among 120 participants, 75 (62.5%) belong to Higher Secondary A Group and 45 (37.5%) belong to Higher Secondary B Group, the frequency and distribution of students based on their type of family. It was observed that among 120 participants, 74 (61.66%) belong to Nuclear Family and 46 (38.33%) belong to Joint Family, the frequency and percentage distribution of students based on their Area of Living. It was observed that among 120 participants, 75 (62.5%) belong to urban area and 45 (37.5%) belong to the Rural Area.

Section B: Analysis of knowledge and practice Regarding Healthy eating among adolescents.

Table 1: Assess the level of knowledge regarding healthy eating among adolescents in selected area if Vadodara.

LEVEL OF KNOWLEDGE	FREQUENCY	PERCENTAGE (%)
POOR	9	7.5%

AVERAGE	55	45.83%
GOOD	56	46.67%
TOTAL	120	100%

The table shows the level of knowledge regarding Healthy eating among adolescents. It was observed that among 120 participants, there was about 9 (7.5%) had poor knowledge, 55 (45.83%) having average knowledge and 56 (46.67%) having good knowledge regarding Healthy Eating Habits.

Table 2: Assess the practice regarding healthy eating among adolescents in selected area of Vadodara

LEVEL OF PRACTICE	FREQUENCY	MEAN	PERCENTAGE (%)
POOR	4	0.03	3.33%
AVERAGE	18	0.15	15%
GOOD	98	0.81	81.67%
TOTAL	120	0.99	100

The table shows the level of Practice regarding Healthy eating among adolescents. It was observed that among 120 participants, there was about 4 (3.33%) had poor practice, 18 (15%) having average practice and 98 (81.67%) having good practice regarding Healthy Eating Habits.

CONCLUSION:

This study was undertaken to assess the frequency and percentage distribution of knowledge and practice regarding Healthy Eating among adolescents in selected Higher secondary school students of Vadodara, 120 samples of higher secondary school was selected on the basis of inclusion and exclusion criteria. The demographic variables were assessed. The level of knowledge and practice where the level of knowledge was found higher whereas the level of practice is found less than the level of knowledge. The association between the knowledge and practice and the correlation is not significant.

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**“A study to evaluate the effectiveness of therapeutic play intervention on
pain distraction among under-five children admitted in
Dhiraj general hospital, Vadodara”**

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Abstract:

Background: Play and recreation are a natural part of childhood, and vital to normal development. Children are able to learn, master experiences, express themselves, cope with anxiety, create, achieve, and develop skills through play and recreational activity. Play also helps children learn to adapt to the healthcare experience. Play and recreation can be therapeutic by giving children the opportunity to explore, express and process their healthcare experiences in a safe, non-threatening environment. **Methods & materials :** Quantitative approach with pre experimental one group pre test post test design including 50 under five children admitted in Dhiraj general hospital were selected as samples using non probability convenience sampling technique and a semi structured questionnaire on demographic profile and standardised FLACC behavioral pain assessment scale was administered to collect data. **Results:** The collected data were tabulated and analysed by using descriptive and inferential statistics. The obtained paired 't' calculated value 28.11 is more than tabulated t value 2.000 at 0.05 level of significance with $df = 49$. The obtained χ^2 value of demographic variables such as age, gender, ordinal position in the family and previous hospitalization are less than the table value of χ^2 at 0.05 level of significance. Hence the obtained χ^2 value is not significant, and the obtained χ^2 value of the variable length of stay in hospital of under five children, is more than the table value at 0.05 level of significance and found significant.

Conclusion: The overall pre-test mean pain score of the under five children was 6.28 and post-test mean pain score was 1.04. The post-test mean pain score is significantly less than the pre-test mean pain score. So the therapeutic play intervention was effective. Therefore **H₁ is accepted.**

Key Words: Effectiveness, Therapeutic play, knowledge, Pain distraction, Under five children.

INTRODUCTION:

Play and recreation are a natural part of childhood, and vital to normal development. Children are able to learn, master experiences, express themselves, cope with anxiety, create, achieve, and develop skills through play and recreational activity. Play also helps children learn to adapt to the healthcare experience. Play and recreation can be therapeutic by giving children the opportunity to explore, express and process their healthcare experiences in a safe, non-threatening environment. Medical play is a commonly used therapeutic activity in which children use medical themes and materials in their play. By observing children's play and recreation, adults can learn about the child's feelings, fears, concerns and misconceptions – information that is crucial in helping children deal with their healthcare experience¹.

Through play children experience a range of emotions including frustration, determination, achievement, disappointment and confidence, and through practice, can learn how to manage these feelings. Play is widely agreed to be the natural mechanism through which children better understand their thoughts and feelings and 'prevent or resolve psychological challenges and learn to manage relationships and conflicts through a natural, self-guided, self-healing process'. Play can be a way for children to make sense of what is happening to them. It can be a means of 'playing out' material in a way that is restorative and healing².

In the hospital context, play is often used for role play and conflicts, promoting catharsis, which signifies relief and purification of the individual. Its curative function is therefore evident, as it allows the child to elaborate her

conflicts and relieve her anxiety. After all, expression through play is the most natural form of self-therapy at the child's disposal³.

LITERATURE REVIEW:

William et al (2016) conducted a non-equivalent control group pre-test and post-test, between subjects in the two largest acute-care public hospitals in Hong Kong. A total of 304 Chinese children (ages 3-12) admitted for treatments in these two hospitals were invited to participate in the study. Of the 304 paediatric patients, 154 received hospital play interventions and 150 received usual care. Children who received the hospital play interventions exhibited fewer negative emotions and experienced lower levels of anxiety than those children who received usual care. This study addressed a gap in the literature by providing empirical evidence to support the effectiveness of play interventions in reducing anxiety and negative emotions in hospitalized children. Findings from this study emphasize the significance of incorporating hospital play interventions to provide holistic and quality care to ease the psychological burden of hospitalized children¹⁷.

Izabel Cristina, (2016) conducted an analytical, exploratory and quantitative study to evaluate the effectiveness of ITP to the management of pain when performing peripheral venipuncture or handling of the venous access in preschool and schoolchildren. To measure the pain of children the Faces Pain Scale (FPS) was used. For data analysis, the Wilcoxon test was used. Before the sessions, 28.6% reported the pain score "1" or absence of pain. After the sessions, 71.4% of the sample indicated the same score. Another important issue before the ITP sessions, the score was "4", which expresses intense pain. After the sessions, 100% of children who have been assigned this face, showed improvement in pain patterns. Thus, the findings of this study corroborate previous studies that show ITP as an important tool in relieving pain presented by hospitalized children, subjected to intrusive and stressful procedures¹⁸.

STUDY OBJECTIVES:

1. To assess the level of pain among the under five children admitted in Dhiraj general hospital
2. To evaluate the effectiveness of therapeutic play intervention on pain distraction
3. To find out the association between pain level and their selected socio-demographic variables.

MATERIALS:

Instrument used for the study

Data collection was planned through interview schedule. A semi structured questionnaire was planned to collect the demographic variables. Standardised FLACC behavioural pain assessment scale was used to assess the pain level of under five children.

Part 1: Demographic data sheet consists of demographic variables.

A semi structured questionnaire was planned to collect the demographic variables, which includes 5 variables. They are Age of the child, gender, ordinal position in the family, length of hospital stay and previous hospitalization of under five children.

Part 2: Standardised FLACC behavioural Pain assessment scale

- Standardized FLACC pain scale was used to assess the pain level of under five children admitted in Dhiraj general hospital.
- It consists of 5 items, which includes facial expression, leg movement, activity, cry and consolability

Scoring interpretation

- 0 – Relaxed and comfortable
- 1 - 3 = Mild pain
- 4 – 6 = Moderate pain
- 7 – 10 = Severe pain

METHOD OF DATA COLLECTION

After obtaining formal administrative approval from the concerned authorities and informed consent from the parents the investigator personally collected the demographic data. After which data was collected in the following three phases;

Phase 1: Pre-test conducted to assess existing level of pain

Phase 2: Administration of therapeutic play intervention

Phase 3: Post test was taken during therapeutic play intervention

METHOD:

VARIABLES UNDER THE STUDY

A variable, as the name implies, is something that varies. A variable is any measured characteristics or attribute that differ for different subjects.

Independent variable:

In the present study the independent variable is therapeutic play intervention

Dependent variable:

In the present study the dependent variable is Level of pain of underfive children admitted in Dhiraj General Hospital.

Selected demographic variables:

In this study age of children, Gender, ordinal position in the family, length of stay in Hospital and previous hospitalization are the demographic variables.

SETTING OF THE STUDY

The study was conducted at pediatric ward of Dhiraj Hospital, Vadodara

TARGET POPULATION

For this study the population was under five children admitted in Dhiraj Hospital.

SAMPLE SIZE

The total number of sample was 50 under five children

SAMPLING TECHNIQUE

In this study the sampling technique was Non probability convenience sampling.

SAMPLE SELECTION CRITERIA

1) Inclusion criteria-

- Under five children admitted in Pediatric ward
- Who is present at the time of data collection

2) Exclusion criteria-

- Underfive children admitted in critical areas
- Children above 5 years of age

DISCUSSION:

The present study was conducted to determine the effectiveness of therapeutic play intervention among underfive children admitted in Dhiraj Hospital, Vadodara.. In order to achieve the objectives of the study, experimental one group pre-test, post-test design was adopted. Convenience sampling technique was used to select the sample. The data was collected from 50 respondents before and after administering therapeutic play intervention. The findings of the study have been discussed with reference to the objectives, hypothesis.

OBJECTIVES OF THE STUDY

1. Assess the level of pain among the under five children admitted in Dhiraj general hospital
2. Evaluate the effectiveness of therapeutic play intervention on pain distraction
3. Find out the association between pain level and their selected socio-demographic variables

ANALYSIS:

Section -I

FREQUENCY AND PERCENTAGE DISTRIBUTION OF AGE OF UNDERFIVE CHILDREN

N = 50

1	AGE GROUP OF CHILDREN	FREQUENCY	PERCENTAGE
	A) 1 month – 12 months	18	36%
	B) 13 months – 24 months	23	46%
	C) 25 months – 36 months	5	10%
	D) 36 months & above	4	8%

Table 1 Shows that majority 23 children (46 %) were 13 months to 24 months old and 18 children (36%) were 1 month to 12 months old and 5 children (10%) were 25 months to 36 months and 4 children (8%) were 36 and above years old.

FREQUENCY AND PERCENTAGE DISTRIBUTION OF SAMPLE ACCORDING TO GENDER

N = 50

2	GENDER OF UNDERFIVE CHILDREN	FREQUENCY	PERCENTAGE
	A) Male	22	44%
	B) Female	28	56%

Table 2 Shows that the majority 28 children (56%) were female children , 22 children (44%) were male children.

FREQUENCY AND PERCENTAGE DISTRIBUTION OF ORDINAL POSITION IN THE FAMILY OF UNDERFIVE CHILDREN

N = 50

3	ORDINAL POSITION IN THE FAMILY	FREQUENCY	PERCENTAGE
	A) First	24	48%
	B) Second	15	30%
	C) Third	7	14%
	D) Fourth & above	4	8%

Table 3 shows that the majority 24 children (48%) were first born child, 15 children (30%) were second child, 7 children (14%) were in third position and 4 children (8%) were in fourth and above position.

FREQUENCY AND PERCENTAGE DISTRIBUTION OF LENGTH OF STAY IN HOSPITAL

N = 50

4	LENGTH OF STAY IN HOSPITAL	FREQUENCY	PERCENTAGE
	A) 1 – 3 days	14	28%
	B) 4 – 6 days	18	36%
	C) 7 – 9 days	14	28%
	D) > 10 days	4	8%

Table 4 Shows that majority 18 children (36%) stay in hospital was 1-3 days, 14 children (28%) stay was between 4-6 days, 14 children (28%) stay was between 7-9 days and 4 children (8%) stay was more than 10 days.

FREQUENCY AND PERCENTAGE DISTRIBUTION OF UNDERFIVE CHILDREN REGARDING PREVIOUS HOSPITALISATION

N = 50

5	PREVIOUS HOSPITALISATION	FREQUENCY	PERCENTAGE
	A) Yes	12	24%
	B) No	38	76%

Table 5 Shows those majority 38 children (76%) had no experience of previous hospitalisation and 12 children (24%) had the experience of previous hospitalisation.

SECTION II

ASSESSMENT OF LEVEL OF PAIN OF UNDERFIVE CHILDREN BEFORE AND AFTER ADMINISTRATION OF THERAPEUTIC PLAY

N = 50

UNDERFIVE CHILDREN PAIN SCORE		
	FREQUENCY	PERCENTAGE
Relaxed & comfortable = 0	0	0
Mild discomfort = 1 – 3	6	12%
Moderate pain = 4 – 6	20	40%
Severe pain = 7 – 10	24	48%

Above table presents that 6 children (12%) had mild discomfort and 20 children (40%) had moderate pain and 24 children (48%) had severe pain and none of them was free from pain.

POST-TEST

N = 50

UNDERFIVE CHILDREN PAIN SCORE		
	FREQUENCY	PERCENTAGE
Relaxed & comfortable = 0	34	68%
Mild discomfort = 1 – 3	16	32%
Moderate pain = 4 – 6	0	0
Severe pain = 7 – 10	0	0

Above table Represents that 34 under five children (68%) were relaxed & comfortable, 16 children (32%) were having mild discomfort.

SECTION III:

EFFECTIVENESS OF THERAPEUTIC PLAY INTERVENTION ON PAIN DISTRACTION AMONG UNDERFIVE CHILDREN

To find the significant difference between the mean pre- test and post- test level of pain, paired “t” test was used. In order to test the significant statistical difference between the mean pre- test and post-test pain score.

TABLE 10: MEAN, STANDARD DEVIATION, MEAN DIFFERENCE AND ‘T’ VALUE OF PRE- TEST AND POST TEST SCORES.

Variables		Mean	Mean difference	SD	SE	t-value	Significance
STRESS SCORE	Pre-test	6.28	4.88	1.51	0.21	28.11*	S
	Post-test	1.04					

*t (0.05, 49) = 2.000

Table 11: This table Depicts mean, standard deviation of pre-test and post-test with the mean difference, SD, SE, paired ‘t’ value, df value of pre-test and post test pain scores. It indicates that there is significant difference between pre and post therapeutic play intervention on pain distraction among under five children.

H₁: There will be significant pain distraction during therapeutic play intervention among under five children admitted in hospital.

To test the hypothesis, paired ‘t’ test was used. The outputs were depicted in the above table. The table reveals that there is significant difference between pre therapeutic play interventional test pain score and post interventional test pain test score with 0.05 level of significant at df = 49. Calculated ‘t’ (28.11) is greater than the tabulated’ value (2.000) hence **H₁ is accepted** and the therapeutic play intervention is found effective.

SECTION - IV

ASSOCIATIONS BETWEEN PRE TEST PAIN SCORE WITH DEMOGRAPHIC VARIABLES

Variables	R	M	M	S	Total	χ^2	Df	Inference
AGE OF UNDERFIVE CHILDREN								
A) 1 – 12 Mts	0	7	2	9	18	7.384	6	NS
B) 13 – 24 Mts	0	9	6	8	23			
C) 25 – 36 Mts	0	1	1	3	5			
D) 36 & above	0	1	1	2	4			
Total	0	18	10	22	50			
GENDER								
A) Male	0	2	10	10	22	0.487	2	NS
B) Female	0	3	10	15	28			
Total	0	5	20	25	50			
ORDINAL POSITION IN THE FAMILY								

A) First	0	2	11	10	23	3.408	6	NS
B) Second	0	2	6	8	16			
C) Third	0	0	2	5	7			
D) Fourth & above	0	1	1	2	4			
Total	0	5	20	25	50			
LENGTH OF HOSPITAL STAY								
A) 1 – 3 days	0	5	4	5	14	23.42	6	S
B) 4 – 6 days	0	0	12	6	18			
C) 7 – 9 days	0	0	4	10	14			
D) > 10 days	0	0	0	4	4			
Total	0	5	20	25	50			
PREVIOUS HOSPITALISATION								
A) Yes	0	3	3	6	12	4.44	2	NS
B) No	0	2	17	19	38			
Total	0	5	20	25	50			

R – Relaxed & comfortable M – Moderate discomfort M – Mild Pain S – Severe Pain

INFERENCE: The obtained χ^2 value = 23.42 of length of stay in hospital of under five children is greater than the table value of $\chi^2 = 12.59$ at 0.05 level of significance with df = 6. Hence the obtained χ^2 value is found significant. It is concluded that there is no significant association between other demographic variables like age group of children, gender, ordinal position in the family, previous hospitalisation with pre test pain scores.

FINDINGS:

Section - I

DISTRIBUTION OF DEMOGRAPHIC VARIABLES OF UNDERFIVE CHILDREN

Demographic variable: Age of the under five children

Majority 23 children (46 %) were 13 – 24 months old and 18 children (36%) were 1 month – 12 months old and 5 children (10%) were between 25 – 36 months and 4 children (8%) were 36 months and above years old.

Demographic variable: Gender of under five children

Majority 28 children (56%) were female children, 22 children (44%) were male children.

Demographic variable: Ordinal position of under five children in the family

Majority 24 children (48%) were first born child, 15 children (30%) were second child, 7 children (14%) were in third position and 4 children (8%) were in fourth and above position.

Demographic variable: Length of hospital stay of under five children

Majority 18 children (36%) stay in hospital was 1-3 days, 14 children (28%) stay was between 4-6 days, 14 children (28%) stay was between 7-9 days and 4 children (8%) stay was more than 10 days.

Demographic variable: Previous hospitalization of under five children

Majority 38 children (76%) had no experience of previous hospitalisation and 12 children (24%) had the experience of previous hospitalisation.

Section - II

ASSESSMENT OF LEVEL OF PAIN OF UNDERFIVE CHILDREN ADMITTED IN WARD BEFORE AND AFTER ADMINISTRATION OF THERAPEUTIC PLAY

Depicts the classification of level of pain among under five children admitted

Pre-test Pain score

Pre-test pain score reveals that 7 under five children (14%) were having mild discomfort and 13 under five children (26%) were having moderate pain and 30 children (60%) were having severe pain.

Mean Pre-test pain score = 6.28

Post-test Pain score

Where Post-test Pain score represents that 34 children (68%) were found relaxed and comfortable, 16 children (32 %) were having mild discomfort and none of the under five children had moderate or severe pain.

Mean Post-test pain score = 1.04

Section III: EFFECTIVENESS OF THERAPEUTIC PLAY INTERVENTION AMONG UNDERFIVE CHILDREN ADMITTED IN DHIRAJ GENERAL HOSPITAL

In the pre-test, mean score was 6.28 and post-test mean score was 1.04. The post-test level of pain mean score is significantly less than the pre-test pains mean score.

The paired 't' calculated value 28.11 is more than tabulated t value 2.000 at 0.05 level of significance with df = 49. So it is concluded that the mean post test pain score is significantly lesser than the pre-test pain score of under five children admitted in Dhiraj general hospital. Therefore **H₁ is accepted**.

Section IV: ASSOCIATION OF PRE-TEST PAIN SCORE WITH DEMOGRAPHIC VARIABLES

The chi-square was used to determine the association between pre-test pain score and selected demographic variables like, age group, gender, ordinal position in the family, length of hospital stay, previous hospitalization.

The obtained χ^2 value in age, gender, ordinal position in the family and previous hospitalization variables are less than the table value of χ^2 at 0.05 level of significance. Hence the obtained χ^2 value is not significant, and the variable length of stay in hospital of under five children, χ^2 value obtained is more than the table value at 0.05 level of significance. Hence there is significant association between those selected demographic variables and pre-test pain score of under five children admitted in hospital.

RESULT:

Result of demographic variables:

- Majority 23 children (46 %) were 13 – 24 months old and 18 children (36%) were 1 month – 12 months old.
- Majority 28 children (56%) were female children, 22 children (44%) were male children.
- Majority 24 children (48%) were first born child, 15 children (30%) were second child,
- Majority 18 children (36%) stay in hospital was 1-3 days, 14 children (28%) stay was between 4-6 days
- Majority 38 children (76%) had no experience of previous hospitalization and 12 children (24%) had the experience of previous hospitalization.

Result of effectiveness of Therapeutic play intervention

In this study the obtained paired 't' calculated value 28.11 is more than tabulated t value 2.000 at 0.05 level of significance with df = 49. So **H₁ is accepted** and concluded that the therapeutic play intervention was effective on pain distraction among under five children admitted in Dhiraj general hospital.

Result of association between demographic variables with pretest Pain score

The obtained χ^2 value in age, gender, ordinal position in the family and previous hospitalization variables are less than the table value of χ^2 at 0.05 level of significance. Hence the obtained χ^2 value is not significant, and the variable length of stay in hospital of under five children, χ^2 value obtained is more than the table value at 0.05 level of significance. Hence there is significant association between the selected demographic variable and pre-test pain score of under five children admitted in hospital.

RECOMMENDATIONS:

- The study can be replicated on a larger sample; thereby findings can be generalized for a larger population.
- A similar study can be conducted by having experimental and control group

CONCLUSION:

In the present study 50 under five children admitted in Dhiraj Hospital, Vadodara were selected by using non-probability convenience sampling technique.

The research approach adopted in the present study is qualitative research approach with a view to assess the level of pain among under five children. Effectiveness was assessed by analysis of pre-test and post-test level of pain score. The data was interpreted by suitable and appropriate statistical method. This chapter deals with the following conclusions;

The overall pre-test mean stress score of the mother was 6.28 and post-test mean pain score was 1.04. The post-test mean stress score is significantly less than the pre-test mean pain score. So the therapeutic play intervention was effective. Therefore **H₁ is accepted**.

The chi-square was used to determine the association between pre-test stress score with demographic variables. The obtained χ^2 value in age, gender, ordinal position in family, previous hospitalization variables are less than the table value of χ^2 at 0.05 level of significance. Hence the obtained χ^2 value is non significant, and the length of stay in hospital variable obtained χ^2 value is more than the table value at 0.05 level of significant. Hence there is significant association between those selected demographic variables and pre-test pain score of under five children admitted in hospital.

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“A study to assess the factors influencing suicidal behaviour among college students at selected nursing colleges of Vadodara, with a view to develop an informational booklet.”

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Abstract: The statement of study is: “A study to assess the factors influencing suicidal behavior among college students at selected nursing colleges of Vadodara, with a view to develop an informational booklet.” In this study Descriptive research design was adopted to achieve the goal of study. The study was conducted in the selected college of Baroda, Sigma Nursing Institute and Sumandeep Nursing College. The sample constricted of 70 college students studying in First year B.Sc. Nursing. Purposive sampling technique was adapted to select the subject. A self administered questioner on factors influencing suicidal behavior was use for the data collection. Out of 70 nursing students ,64 students has mild influencing suicidal behavior (91.4%),5 students has moderate influencing suicidal behavior (7.1%) and one student has high risk influencing suicidal behaviour (1.4%). It can be concluded that the physical factor are highly responsible for influencing suicidal behavior among college students followed by family factors, academic factor, socioeconomic factor psychological factor and major life events are less responsible for influencing suicidal behavior among college students.

Key Words: Assess, factor influencing, suicidal behavior, among college students.

INTRODUCTION:

The World Health Organization has defined "adolescents" as persons who belongs to 10 to 19-year age group. Today India has a population of adolescents and youth that is among the largest in the world. This is the generation, which will shape India's future. One of the most important commitments a country can make for its future economic, social, and political progress and stability is to address the health- and development-related needs of its adolescents.¹

The word 'suicide' has its origin in Latin; 'sui', of one self and 'cadre', to kill: the act of intentionally destroying one's life. The phenomenon of suicide has at all times attracted the attention of moralists, social investigators, philosophers and scientists. The modern era of the study in suicide began around the turn of the 20th century, with two main threads of investigation, the sociological and the psychological, associated with the names of Emile Durkheim (1858- 1917) and Sigmund Freud (1856-1939), respectively. Suicidal behavior represents a spectrum, ranging from suicidal ideation to suicidal plan to suicidal attempt to completed suicide.²

LITERATURE REVIEW:

Omigbodun O A study conducted on prevalence and Correlates of Suicidal Behavior Among Adolescents. Despite being recognized by the World Health Organization as a significant social and health concern, information on suicidal behaviors in adolescents is unknown. Aim of the study is to establish the prevalence and associated psychosocial correlates of suicidal ideation and attempts in Nigerian youth. Stratified sampling was used to identify youth aged 10-17 years who completed the Diagnostic Predictive Scale (DPS) for youths (suicidal behavior questions) in a classroom setting. Results of study shows a total of 1429 youth completed the instruments. Over 20% reported suicidal ideation and 21 approximately 12% reported that they had attempted suicide in the last year. Adolescents living in urban areas, from polygamous or disrupted families, had higher rates of suicidal behavior. Multiple psychosocial factors such as sexual abuse, physical attack and involvement in physical fights were significant predictors of suicidal behaviour.³

J Jeneesh As per the censuses of 2001, India has a population of 102.53 cores and Kerala has a population of 3.18 Crores (i.e., 3.1 % of National Population) But 10.1 % of all the suicides in India is reported from Kerala. During the period from 1991-2002 population growth reported in Kerala is 2.2 % but the increase in suicide rate reported is 4.6%. As per the available statistics of 2002 Kerala has the highest suicidal rate (30.8/Lakh.) among other states. The National rate is only 11.2/Lakh and the Global rate is 14.5/Lakh. The total number of Suicides reported in Kerala during 2002 is 9810 i.e., 27/day or one suicide per hour (1/hr). The corresponding ratio of suicide in India is 1/5mts and the Global rate is 1/40sec Kerala is first in the suicide rate for the 7th time. DSH is 8-20 times more than completed suicide and approximately Nearly 14 persons attempt suicide per hour in our state. Suicide rate in young people is also increasing in Kerala. Family Suicide is also increasing in Kerala. This has increased from 38 families to 53 families during 1998 to 2000.⁴

STUDY OBJECTIVES & HYPOTHESIS:

- To assess the factors influencing suicidal behavior among college students.
- To find the association between factors influencing suicidal behavior with selected demographic variables.
- To prepare an information on preventive measures regarding suicidal behavior among college student.

MATERIALS:

Variables: 2 types of variables are identified in this study. They are independent, dependent and extraneous variables.

Research Variable: The factors influencing suicidal behavior are physical factors.

Demographic variables: The demographic variables in this study were Age, sex, religion, occupation, income, education, and type of family, family history of mental disorder and substance abuse area of living and source of information about suicidal behavior.

Description of the tool:

The tool was used for data collection was self-administered questionnaire on factors influencing suicidal behavior having 45 items. It consisted of two sections.

Section 1: Demographic variables.

Section 2: Self administered questionnaire on factors influencing suicidal behavior.

Section 1: Demographic variables

Demographic variables with 12 items on Age, Sex, Religion, occupation, income, education, type of family, family history of mental disorder and substance abuse area of living and source of information about suicidal behavior.

Section 2: Self administered questionnaire on factors influencing suicidal behavior.

Questionnaire consists of 45 questions covering the following area :

Socioeconomic factors, Psychological factors, Family factors, Physical factors, Academic factors, Major life events.

The items placed on a checklist. The checklist consists of 45 items, to be judged as 'Yes' and 'No'. The 'yes' response was given '1' score, and 'No' response was given '0' score with a total aggregate of 45 score.

Reliability: The reliability of tool established by using split half method Spearman Brown Prophecy formula ($r=0.75$) reliability test.

METHOD:

Research design: The research design used was descriptive survey design

Research Setting: 1st year B.Sc students studying in Sigma Institute of Nursing and Sumandeep Nursing College, Vadodara.

Sample : 70 College students

Method of data Collection

Self administrated questionnaire on prevention of suicidal behavior or Analysis and interpretation communication of finding.

Inclusive Criteria:

- Students belonging to the First Year B.Sc. nursing
- Students who are willing to participate in the study.
- Students who can read, write and understand English.

Exclusion criteria:

- Students not willing to participate in the study.
- Students absent during the study.
- Students who are already diagnosed with any mental illness.

DISCUSSION:

This study has undertaken to assess the factors influencing suicidal behavior among the college Students at selected nursing colleges in Vadodara, with a view to develop an informational booklet. The objectives of the study are to assess the factors influencing suicidal behavior among college students, to find the association between factors

influencing suicidal behavior with selected demographic variables and to prepare an informational booklet on preventive measures regarding suicidal behavior among college students. In this study 70 samples are taken and non probability purposive sampling technique is used. Analysis of obtained data was planned based on the objectives and hypothesis of the study, both descriptive and inferential statistics were used for the analysis of the data. Out of 70 Nursing students, 64 students has mild influencing suicidal behavior (91.4%), 5 students has moderate influencing suicidal behavior (7.1%) and 1 students has high risk influencing suicidal behavior(1.4%).

ANALYSIS:

Table 1: Frequency and percentages distribution of nursing students, according to their demographic characteristic. n=70

Demographic Data	Characteristics	Frequency	Percentage%
AGE IN YEAR	18-20 years	67	96
	20-22 years	3	4
GENDER	Male	32	46
	Female	38	54
RELIGION	Hindu	63	90
	Christian	1	2
	Muslim	6	9
	Other	0	0
OCCUPATION OF FATHER	Agriculture	16	23
	Business	16	23
	Private Service	21	30
	Government Service	13	19
	Unemployed	4	6
OCCUPATION OF MOTHER	Agriculture	1	2
	Business	1	2
	Private Service	6	9
	Government Service	7	10
	Housewife	55	78
MONTHLY INCOME OF FAMILY	Below Rs 2000	6	9
	Rs 2001-4000	8	12
	Rs 4001-5000	16	23
	Rs Above 6001	40	57
TYPE OF FAMILY	Nuclear Family	30	43
	Joint Family	30	43
	Extended Family	2	3
	Single Parent Family	8	12
SOURCE OF INFORMATION ABOUT SUICIDAL BEHAVIOR	Television	34	49
	Radio	0	0
	News Paper	10	14
	Movies	21	30
	Magazine	0	0
	Book	3	4
FAMILY HISTORY OF MENTAL ILLNESS	Depression	9	0
	Schizophrenia	0	0
	Mania	0	0
	Any Other	1	1
	None Of Above	60	86
FAMILY HISTORY OF SUBSTANCE ABUSE	Drug Abuse	0	0
	Smoking	3	4
	Alcohol Dependence	2	3
	Any Other	1	1
	None Of Above	64	92

AREA OF LIVING	Urban	42	60
	Rural	28	40

Table 2: Frequency and distribution of mean, SD and mean percentages of nursing students.
 n=70

Sr. NO	KNOWLEDGE ASPECT	MAXIMUM SCORE	MEAN SCORE	MEAN PERCENTAGE	SD
1	Socioeconomic Factor	11	1.75	15.9%	1.84
2	Psychological Factor	8	0.9	11.25%	1.47
3	Family Factor	8	1.6	20%	1.54
4	Physical Factor	6	1.32	22%	0.93
5	Academic Factor	8	1.44	18%	1.87
6	Major Life Event	4	0.35	8.75%	0.61
Overall score		45	7.36	16.35%	8.26

Table 3: Frequency and distribution of Selected Demographic Variables with Factors Influencing Suicidal Behavior

Sr. no.	Variable	0-15	16-30	31-45	Total	x ²	DF	Level of significance
1	AGE					0.294	2	0.294<5.99 NS
	18-20 Year	61	5	1	67			
	20-22 year	3	0	0	3			
	TOTAL	64	5	1	70			
2	GENDER					1.628	2	1.628<5.99 NS
	Male	24	2	1	27			
	Female	40	3	0	43			
	TOTAL	64	5	1	70			
3	RELIGION					0.729	4	0.729<9.49 NS
	Hindu	57	5	1	63			
	Christian	1	0	0	1			
	Muslim	6	0	0	06			
	TOTAL	64	5	1	70			
4	OCCUPATION OF FATHER					12.377	8	12.377<15.51 NS
	Agriculture	13	2	1	16			
	Business	16	0	0	16			
	Private sector	21	0	0	21			
	Government service	10	3	0	13			
	Unemployed	4	0	0	4			
	TOTAL	64	5	1	70			
5	OCCUPATION OF MOTHER					26.630	8	26.630>15.51 S
	Agriculture	0	1	0	1			
	Business	1	0	0	1			
	Private services	6	0	0	6			
	Government services	5	2	1	8			
	House wife	52	2	0	54			
	TOTAL	64	5	1	70			
6	MONTHLY INCOME OF THE FAMILY					7.129	6	7.129<12.59 NS
	Below Rs. 2000	5	1	0	6			
	Rs.2001-4000	9	0	0	9			

	Rs.4001-5000	12	3	0	15			
	Rs.6001 and above	38	1	1	40			
	TOTAL	64	5	1	70			
7	TYPE OF FAMILY							
	Nuclear	28	2	0	30	8.865	6	8.865<12.59 NS
	Joint	27	3	0	30			
	Extended	2	0	0	2			
	Single parent	7	0	1	8			
	TOTAL	64	5	1	70			
8	SOURCE OF INFORMATION							
	Television	33	1	1	35	3.941	6	3.941<12.59 NS
	Newspaper	9	1	0	10			
	Movies	18	3	0	21			
	Book	4	0	0	4			
	TOTAL	64	5	1	70			
9	FAMILY HISTORY OF MENTAL ILLNESS							
	Depression	6	2	1	9	10.795	4	10.795>9.49 S
	Schizophrenia	00	0	00	0			
	Mania	0	0	0	0			
	Any other	1	0	0	01			
	None of the above	57	3	0	60			
	TOTAL	64	5	1	70			
10	FAMILY HISTORY OF SUBSTANCE ABUSE							
	Drug abuse	0	0	0	0	23.232	6	23.232>12.59 S
	Smoking	2	1	0	3			
	Alcohol dependence	1	1	0	2			
	Any other	0	1	0	1			
	None of the above	61	2	1	64			
	TOTAL	64	5	1	70			
11	AREA OF LIVING							
	Urban	41	1	0	42	5.273	2	5.273<5.99 NS
	Rural	23	4	1	28			
	TOTAL	65	5	1	70			

FINDINGS:

There are 54% female nursing students and 46% of male nursing students are involving in this study. In this study there are 32 nursing male students and 38 nursing female students are involved.

In this study age group 18-20 with 67 nursing students, age group 20-22 has only 3 students, so the age group 18-20 has more numbers of nursing students. There are 90% of Hindu, 1.42% of Christian, 8.58% of Muslim and 0% from other religion. 0% of the students from the second year B.Sc nursing only first year students are involved in this study. The percentage of the occupation of father of nursing students in private service with 30%, the business and agriculture are equal percentage 23% which are second highest in the chart, 18% of parents are doing government job, were 6% are unemployed. Percentage Of The Occupation of the Mother of Nursing Student is 78% housewife, agriculture and business women are 1.42%, 8% women's are work in private sector, 7% mother has government job. In this study the percentage about the monthly family income is 57.14% who's salary is more than 6001 and other side the 22.85% of student family has a 4001-5000 salary per month, 11.42% student family has a 2001-4000 salary per month and only 8.57% students family income is less than 2000. The percentage about the type of the family of the nursing students shows the nuclear and joint family has a equal number of percentage 42.85%, and single parents family has 11.42% and only 2 students are belong from extended family.

The source of information about suicidal behavior show that Television has highest percentage 48.57%, option Radio and Magazine has 0%, option Newspaper has 14.2%, Movies has a second highest in the table with 30%. The percentage of the any mental illness in the family history shows that Depression has 12.85%, Schizophrenia has 0%, Mania has 0%, Any other illness has 1.42% and 85.71%. we analysis that the most of the students has no any kind of mental illness history. History of substance abuse in the students family shows that 91.42% has no history of substance abuse, drug abuse has 0%, Smoking has 4.28%, Alcohol Dependence has 2.85%, Use of any other substance

has 1.42% . There are 42 students are living urban area and in rural area there are 28 students are living. In this study analysis of factors affecting the suicidal behaviour analyze in terms of frequency percentage and standard deviation. There are six main factors that influence for suicidal behavior, physical factor with the highest min score 22% after that, the family factor min score is 20% affect for the suicidal behavior after that academic factor has 18% min score which is third in the table after that socio economic factor min score is 15.9% after that psychological factor mean score is 11.25% after that major life event 8.7% mean score. The total means score 16.35% whit 8.26 standard deviation. It can be concluded that the physical factor are highly responsible for influencing suicidal behavior among college students followed by family factors, academic factor, socio economic factor , psychological factor and major life events are less responsible for influencing suicidal behavior among college students.

RESULT:

From 12 demographic variable the chi square values are, age (0.294), Gender (1.628), Religion(0.729), Education (0), Occupation of father (12.377), Occupation of mother *(26.630), Monthly income of family (7.129), Type of family (8.865), Source of information (3.941), Family history of mental illness (10.795), Family history of substance abuse(23.232) and Area of living(5.273). Out of 70 nursing students ,64 students has mild influencing suicidal behavior (91.4%),5 students has moderate influencing suicidal behavior (7.1%) and one student has high risk influencing suicidal behavior(1.4%). It can be concluded that the physical factor are highly responsible for influencing suicidal behavior among college students followed by family factors, academic factor, socioeconomic factor psychological factor and major life events are less responsible for influencing suicidal behavior among college students.

RECOMMENDATIONS:

Keeping in view the findings of the present study the following recommendations Mare made. Since this study was carried out on a small sample, the results can be used only as a guide for further studies.

- a. A similar study can be replicated by using a large sample.
- b. A similar study can be conducted with different age groups.
- c. A similar study can be replicated with randomization in selected participants.
- d. A study can be conducted to evaluate the effectiveness of information guide sheet on risk factors of suicide and prevention.
- e. A comparative study can be conducted to compare the findings of rural and urban respondents to assess factors influencing suicidal behavior.

CONCLUSION:

It can be concluded that the physical factor are highly responsible for influencing suicidal behavior among college students followed by family factors, academic factor, socioeconomic factor psychological factor and major life events are less responsible for influencing suicidal behavior among college students.

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“Experiences and challenges regarding breastfeeding among primi mothers of neonate: descriptive phenomenological study.”

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Introduction: Breastfeeding is a most beautiful experience of parenthood. It is the best example of God's blessings for a new life. Breastfeeding is one of the most natural way to feed the babies. It provides all the essential nutrients for better growth and development. So to induce this experience, & to eliminate challenges, researchers intended to explore the experience and challenges of Breastfeeding among mothers so that researchers can understand their phenomena regarding breastfeeding and can support mothers and family by providing services need at each stage. **Methodology:** Descriptive Phenomenological study was conducted on 8 sample selected by Convenient sampling technique, Semi structured interview schedule was used with in depth interview, data was obtained in various sessions until the all saturation of information had not happened. Descriptive Phenomenological research has undergone with four stages, bracketing, Intuiting, Analyzing, Describing. **Analysis:** After following all the stages researchers formed following 5 categories and subcategories according to the transcribe verbatim: Mother as a learner, Emotions of mother, Wrong idea, Disturbed daily routine, Importance of Breastfeeding. **Conclusion:** results showed that there are many mothers who face some challenges that breastfeeding causes them trouble but at the end they experience, realize that it's a complete pack of nutrition for the better growth and development of their child. Thus they develop mix feelings and emotions towards breastfeeding.

Key Words: Experience; Challenges; Breastfeeding; Primi mothers; Descriptive phenomenological Study.

INTRODUCTION:

Breastfeeding is most beautiful experience of the world. It provides all the essential nutrients for better growth and development. It establish loving bond between mother and child, even between baby and family. There are copious advantages of breastfeeding. It is indeed a pleasure time for mother and her child as well. The awesome experience of mother has no words to explain her emotions while breastfeeding¹. WHO and UNICEF jointly recommend mothers to breastfeed their newborn within 1st hour after delivery and should continue till 6 months of age that is called Exclusive Breast Feeding. Many organizations are working in order to boost exclusive breastfeeding.²

So to induce this experience researcher intended to explore the experience and challenges of Breastfeeding among mothers so that researchers can understand their phenomena regarding breastfeeding and can support mothers and family by providing services needs at each stage.³

STUDY OBJECTIVE:

- To explore the experience and challenges regarding breastfeeding among primi mothers.

MATERIALS:

Section-I Demographic variables such as Age of mother, age of neonate, frequency of breastfeeding per day, time of initiation of 1st breastfeeding after delivery, status of employment, education status of mother, type of Family and prior Information regarding exclusive breastfeeding.

Section-II: This section Deals with codes, categories, subcategories : Researchers formed 5 categorie Mother as a learner, Emotions of mother, Erroneous idea, Disturbed daily routine and Importance of Breastfeeding

METHOD:

In this research study an qualitative descriptive approach with descriptive phenomenological research design is used. The sampling techniques was non probability convenience sampling is used to collect the 08 samples of primi mothers. Descriptive Phenomenological research has undergone with four stages : Bracketing , Intuiting ,Analysing & Describing. Data was analysed by using Interviews were conducted by Author, then they were read and reread, and script was written and descriptive codes were formulated followed by their categories and subcategories against particular dialogues or verbatim.

DISCUSSION:

Mother as a Learner: This category represents the mother is tend to learn many things from many sources, according to it this category is further divided in 5 subcategories; N urse(As sister taught me I have started breastfeeding), family influence(My mother was teaching me everything), media (Yes, I have learnt many things from some breastfeeding advertisement for Exclusive Breastfeeding). Systematic planning (Hospitals may have plan some more effective sessions in order to bring more awareness regarding breastfeeding.) Antenatal counseling(I had visited Antenatal counselling clinic and it helped me a lot to make my child care, breast feeding better.)

Emotions of mother: This category entitled emotions of phenomena, it is divided in 4 subcategories, such as; Happy(I feel very happy when my baby breastfeeds.) Confused (In the beginning I was totally confused regarding Breastfeeding.)Tensed (I feel so tensed whether my baby is getting proper feed or not) Satisfied (When she is been kept on my breast I feel satisfied and blessed)

False idea: This category replicates that how mothers do some malpractice while feeding, it is divided in 3 subcategories; Consumption of “Gadthuthi” (As per our rituals my in-laws gave honey (Gadthuthi) on the second day after delivery) Discarding colostrums (In our custom we don’t give first dark yellow thick milk to child, we have to discard it as it is a dirty one.) Sickness of mother (I avoid breastfeeding because I have cold, so that my child may not get infection)

Disturbed daily routine: This category shows that due to breastfeeding mother are getting disturbed in day to day life. Its categories in 5 subcategories; Shyness (I feel very shy to breastfeed in public) Uncomfortable clothing (Due to breastfeeding practice I can’t wear my favourite clothing , I have to wear loose cloths.) Reduced rest, comfort (I can’t rest enough whenever she cries I have to wake up for breastfeed even if I am sleeping.) Pain (My baby sucks so hard thus I get pain during breastfeeding.) Loathed food (I can’t consume my favourite food, I don’t remember. When I had my favourite Spicy food last time.).

Importance of Breastfeeding: This category says that some of the mother believes in advantage of breastfeeding, its divided in three subcategory; Complete pack (Exclusive breast feeding should be continued for 6 months as it gives all the essentials nutrition to my child) Boost Immunity (First thick milk increases immunity of my child so I always give it) Bonding (Now a days due to breastfeeding I feel my whole family is enjoying togetherness).

ANALYSIS:

- Interviews were conducted by Author, then they were read and reread, and script was written.
- Descriptive codes were formulated followed by their categories and subcategories against particular dialogues or verbatim.

RESULT:

Section I : Frequency and Percentage distribution of demographic variables

S.No.	Variable	Frequency	Percentage
1.	Age of Mother		
	A. ≤20 years	0	0
	B. 21-25 Years	6	75%
	C. 26-30 Years	2	25%
	D. ≥31 years	0	0
2.	Age of child		
	A. 0-10 days	5	62.5%
	B. 11-20 days	3	37.5%

	C. 21-28 days	0	0
3.	Frequency of Breastfeeding per day		
	A. ≤ 3 times/ day	0	0
	B. 4-8 times/ day	0	0
	C. ≥ 9 times/ day	8	100%
4.	Time of Initiation of breastfeeding after delivery		
	A. < 2 Hours	1	12.5%
	B. 3-4 Hours	7	87.5%
	C. 5-6 Hours	0	0
	D. ≥ 7 Hours	0	0
5.	Employment style of Mother		
	A. Employed	3	37.5%
	B. Unemployed	5	62.5%
6.	Qualification of Mother		
	A. High school	6	80%
	B. Graduate	2	20%
	C. Postgraduate and above	0	0
7.	Type of Family		
	A. Nuclear	1	12.5%
	B. Joint	5	62.5%
	C. Extended Family	2	25%
8	Does Mother have any Prior information regarding Exclusive Breastfeeding?		
	A. Yes	2	25%
	B. No	6	75%

Inference: Above mentioned table says that 75% sample age is 2125 Years, 25% sample age is 2630 years. 62.5% sample neonate's age is below 10 days, 37.5% neonate is 11 to 20 days of age. 100% sample breastfeed their neonates more than 9 times per day. 12.5% sample have started their first breastfeed within 2 hours of delivery, 87.5% have started within 34 hours after delivery. 37.5% sample are employed, 62.5% sample are unemployed. 12.5% sample live in Nuclear family, 62.5% live joint family, 25% live in Extended Family, 25% mother has prior knowledge regarding Exclusive breast feeding where as 75% mother doesn't have prior knowledge.

Section II: This section Deals with codes, categories, subcategories.

Researchers formed 5 categories: Mother as a learner, Emotions of mother, Erroneous idea, Disturbed daily routine, Importance of Breastfeeding and each of those categories are further divided in various subcategories according to the transcribe verbatim.

Categories	Subcategories	Dialogues
Mother as a learner	Nurse educator	As sister taught me I have started breastfeeding
	Family Influence	My mother was teaching me everything
	Media	Yes, I have learnt many things from some breastfeeding advertisement for EBF
	Systematic planning	Hospitals may have plan some more effective sessions in order to bring more awareness regarding breastfeeding.
	Antenatal counseling	I had visited Antenatal counseling clinic and it helped me a lot to make my child care, breastfeeding better.
Emotions of mother	Happy	I feel very happy when my baby breastfeed
	Confused	In the beginning I was totally confused regarding Breastfeeding.
	Tensed	I feel so tensed whether my baby is getting proper feed or not
	Satisfied	When she is been kept on my breast I feel satisfied and blessed

Wrong idea	Consumption of “Gadthuthi”	As per our rituals my in-laws gave honey(Gadthuthi) on the second day after delivery
	Discarding colostrums	In our custom we don’t give first dark yellow thick milk to child, we have to discard it as it is a dirty one.
	Sickness of mother	I avoid breastfeeding because I have cold, so that my child may not get infection
Disturbed daily routine	Shyness	I feel very shy to breastfeed in public
	Uncomfortable clothing	Due to breastfeeding practice I can’t wear my favorite clothing, I have to wear loose cloths.
	Reduced rest, comfort	I can’t rest enough whenever she cries I have to wake up for breastfeed even if I am sleeping.
	Pain	My baby sucks so hard thus I get pain during breastfeeding.
	Loathed food	I can’t consume my favorite food, I don’t remember. When I had my favorite Spicy food last time.
Importance of Breastfeeding	Complete pack	Exclusive breast feeding should be continued for 6 months as it gives all the essentials nutrition to my child
	Boost Immunity	First thick milk increases immunity of my child so I always give it
	Bonding	Now a days due to breastfeeding I feel my whole family is enjoying togetherness

Inference: researchers formed 5 categories: Mother as a learner, Emotions of mother, Erroneous idea, Disturbed daily routine, Importance of Breastfeeding and each of those categories are further divided in various subcategories according to the transcribe verbatim .

CONCLUSION:

In this current study research have done descriptive phenomenological study to explore the experience and challenges of prim mothers regarding breastfeeding, results showed that there are many mothers of think that breastfeeding causes them trouble but at the end they realize that it’s a complete pack of nutrition for the better growth and development of their child. Thus they develop mix feelings and emotions towards breastfeeding.

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**“Assess the level of anxiety among the primi pregnant mothers attending
Dhiraj hospital, Vadodara”.**

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Abstract: BACKGROUND: Prenatal anxiety is a normal and natural experience. It can affect a person's feelings, thoughts, behaviour, and physical well-being. The majority of maternal deaths are due to haemorrhage, infection, unsafe abortion, and eclampsia which is due to knowledge deficit and anxiety. **METHOD:** The research approach was an exploratory approach. The study was conducted using the Univariate descriptive design which includes 150 respondents from the outpatient department of the Dhiraj general hospital, Piparia, Waghodia. Nonprobability convenient sampling technique was used. The data was collected by using standardized Zung anxiety rating scale. The data was tabulated and analysed in terms of objectives of the study, using descriptive and inferential statistics. **RESULT:** With regards to the assessment, out of 150 primi pregnant mothers 23 (15%) having normal range of anxiety, 102 (68.0%) having mild to moderate anxiety levels, 20 (13.3%) mothers having severe anxiety level, 5 (3.3%) having extreme anxiety level. The association is done between anxiety level among primi pregnant mothers and demographic variable. So hypothesis H1 is rejected and conclude that there is no significant association between anxiety level among primi pregnant mothers and demographic variable. The purpose of the study is to assess the level of anxiety among 150 primi pregnant mothers. The findings of the study concluded that there is no significant association between anxiety level of primi pregnant mothers and demographic variable.

INTRODUCTION:

Childbirth is one of the greatest events in every woman's life, especially among primi pregnant mothers. Having had fantasies about pregnancy and motherhood when confronted with the reality many of them doubt their ability to cope with this great event in their lives. Many of the mothers do not know about what changes take place and their role in the presence of childbirth. At this time, the mother needs a lot of help for the realization and acceptance of childbirth as a normal physiological phenomenon¹.

Pregnancy is the time during which one or more offspring develops inside a woman. It usually lasts around 40 weeks from the LMP and ends in Childbirth. Pregnancy is a wonderful period in a woman's life and she spends each and every day in pleasant anticipation, waiting to hold her bundle of joy in her arms. Even though it is a time of great happiness and fulfilment of the life, pregnancy causes a lot of mental conflicts and feelings which is a natural trend of this period. However, in some women these feelings are more intense and lead them to childbirth anxiety².

STUDY OBJECTIVES:

- To find out the level of anxiety among primi pregnant mothers.
- To suggest the suitable measures for reducing anxiety among primi pregnant mothers.
- To associate the level of anxiety with demographic variables.

MATERIALS & METHOD:

- ❖ **Research design**
 - The research design used was Univariate descriptive design
- ❖ **Research Setting**

- Primi pregnant mother from a selected Dhiraj Hospital, Vadodara

❖ Sample

- 150 Primi pregnant mother

❖ Inclusive Criteria

- Primi pregnant mother who attending OPD of Dhiraj hospital.
- Mothers who are willing to participate of Dhiraj hospital.
- Mothers who having previous history of stress disorders.

❖ Exclusive Criteria

- Mothers who are having any Obstetric and medical complications
- Mothers who are admitted in labour room with more than 7 cm cervical dilatation.
- Mothers who are receiving sedative or analgesics drugs.

❖ Description of tools

➤ Section-1 Demographic variable

- Demographic variables are, age, educational status, type of family, monthly family income, occupations, and trimester

➤ Section-2 Zung anxiety rating scale

- Zung anxiety rating scale was used to asses to anxiety among prim pregnant women's.

➤ SCORING PROCEDURE:

- Scoring for anxiety assessment if mother having,
 - If anxiety is present for a little of time score is 1.
 - If anxiety is present for some of the time score is 2.
 - If anxiety is present for good part of time score is 3.
 - If anxiety is present for a most of the time score is 4

❖ Scoring Interpretation

- Normal range of anxiety : 20-44
- Mild to moderate range of anxiety : 45-59
- Severe range of anxiety : 60-74
- Extreme range of anxiety : 75-80

❖ Reliability

The reliability of tool established by using split half method Spearman Brown Prophecy formula ($r=0.75$) reliability test.

❖ Data collection procedure

The data for main study was collected from 150 primi pregnant mothers who are attending at Dhiraj hospital Vadodara who fulfilled the inclusive criteria by convenient sampling technique and the Zung anxiety rating scale was used to assess the anxiety level among primi pregnant mothers who are attending at Dhiraj hospital, Vadodara.

The data for main study was collected on 25/2/19, 26/02/19, 27/03/19, 28/03/19 01/03/19 and 02/04/19, Consent was taken from the participants and the primi pregnant mothers was assessed by using the standardized Zung anxiety rating scale followed by administration of “suggested some suitable measures to primi pregnant mothers.”

DISCUSSION:

The present study was conducted to assess the anxiety level among the primi pregnant mothers. In order to achieve the objectives of the study, a descriptive survey design was adopted. Nonprobability Convenient sampling technique was used to select the sample. The data was collected from 150 respondents by using standardized zung anxiety rating scale. The findings of the study have been discussed with reference to objectives, hypothesis, and with the findings of other studies.

ANALYSIS:

Data were verified prior to computerized entry. The Statistical Package for Social Sciences (SPSS version 20.0) was used. Descriptive statistics were applied (e.g., mean, standard deviation, frequency and percentages). Test of significance (chi square test) was applied to test the study hypothesis.

FINDINGS:

- ❖ Section A: Frequency and Percentage distribution of samples according to their demographic characteristics.

n =150

Sr no.	Demographic variable	Categories	No of respondents in frequency	No of respondent in percentage
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1.	AGE IN YEARS	18-22	53	35.3%
		23-27	60	40%
		28-32	35	23.3%
		33-34	02	1.33 %
2.	EDUCATIONAL STATUS	Illiterate	16	10.66%
		Up to 10th	98	65.33%
		Up to 12th	35	23.33%
		Graduate	1	0.66%
		Post graduate	0	0
3.	TYPE OF FAMILY	Nuclear	22	14.66%
		Joint	128	85.33%
4.	FAMILY INCOME MONTHLY	Below 5000	40	26.66%
		5000-10,000	93	62%
		10,000-20,000	17	11.33%
		20,000-30,000	0	0
		Above 30,000	0	0
5.	OCCUPATION	Housewife	146	97.33%
		Health professional	3	2%
		Other Occupation	1	0.66%
6.	TRIMESTER	1 st trimester	56	37.3%
		2 nd trimester	46	30.6%
		3 rd trimester	48	32%
7.	PREVIOUS HISTORY OF STRESS DISORDER	Posttraumatic stress disorder	0	0
		Acute stress disorder	0	0
		Anxiety disorder	0	0
		None	150	150%

Majority of (40%) primi pregnant mothers were in the age group of 23-27 years and minimum (1.33%) were in the group of 33-35 , (23.3%) in the age group of 28-32 and (35.3%) in the age group of 18-22yrs. Majority of them (65.33%) primi pregnant mothers were up to 10th minimum (0.66%) were up to graduate, illiterate are (10.66%) and up to 12th are (23.33%). Majority of (85.33%) primi pregnant mothers belongs to joint family were nuclear family are (14.66%). Majority of (62%) were having 5000-10,000 family monthly income, minimum (11.33%) having 10,000-20,000 and below 5000 (26.66%). Majority of (97.33%) women's are housewife's and minimum (0.66%) are other occupation and (2%) are health professional. None of them having a history of stress disorder (100%).

Section - B

7. Frequency and percentage distribution of respondents according to Anxiety level of primi pregnant mothers.

In this study it highlights that the out of 150 primi pregnant mothers, Normal range having (15%), mild to moderate anxiety level having (68.0%), marked to sever anxiety level having (13.4%) and extreme anxiety level (3.6%).

8. To suggest the suitable measures for reducing anxiety among primi pregnant mothers.

In this study 150 primi pregnant mothers were selected. Out of 150 primi pregnant mothers 102 were found to be mild to moderate anxiety level, 23 mothers were found to be normal range, 20 of them found to be marked to sever

anxiety level and 5 were found to be extreme anxiety level. The mothers were provided with some suitable measures thereby, they decrease the anxiety level during their pregnancy. It is suggested that mothers should avoid late pregnancy, because risk increases after age of 30 and create delivery complications.

Family members should have good relationship with the pregnant mothers, which can reduce the level of anxiety during pregnancy. Pregnant mothers are suggested to adopt to relaxation therapies such as yoga, meditation Counseling should be suggested for the pregnant mothers regarding the diet, importance of periodic check- up and about child bearing practice.

RECOMMENDATIONS:

- **Based on the findings of the present study recommendation offered for the future study:** The comparative study can be conducted between primi pregnant mothers and multi pregnant mothers.

CONCLUSION:

- The purpose of the study is to assess the level of anxiety among 150 primi pregnant mothers. The findings of the study concluded that there is non-significant association between anxiety level of primi pregnant mothers and demographic variable. .

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“A descriptive study to assess knowledge regarding protein energy malnutrition among mother of under five year children attending paediatric OPD at selected hospital Vadodara.”

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Abstract:

BACKGROUND: Good nutrition promotes normal growth and development of children in life. The relationships between food, nutrition and health have long been recognized. Protein Energy Malnutrition (PEM) or Protein Calorie Malnutrition (PCM) is a widespread nutritional disease in the developing countries.

AIM: The present study was conducted with the objective to assess existing knowledge regarding prevention and control of protein energy malnutrition among mother of less than five year children and identify association between knowledge score with selected demographic variables.

METHOD: A quantitative research approach with descriptive one group pre test design was used. 60 samples were selected by using purposive sampling technique. A structured questionnaire was prepared to assess the knowledge regarding protein energy malnutrition among mother of fewer than five year children.

RESULT: The result shown that majority participants, 78% have average knowledge related protein energy malnutrition, 22% have poor knowledge regarding protein energy malnutrition. The Chi Square test was used to identify association between knowledge score with selected demographic variable. Monthly income of family (13.99>5.99) significant at 0.05 level of significance, demographic variable i.e. age of mother, religion, type of family, occupation, education, dietary pattern, number of under five children in the family, and any previous knowledge regarding malnutrition were non-significant at 0.05 level of significant hence H₁ hypothesis is partially accepted.

CONCLUSION: The study concluded that majority of mother has average knowledge related protein energy malnutrition.

Key Words: Descriptive study, knowledge, protein energy malnutrition, mother of under five year children.

INTRODUCTION:

Children are making seeds for the future. They deserve the utmost care from us. They are like wet clay in the hand of a potter.¹ Good nutrition promotes normal growth and development of children in life. The relationships between food, nutrition and health have long been recognized. A nation's health depends on healthy citizens. A healthy adult emerges from healthy child. Children are priceless resources and if the nation neglects their health it would become a nation of unhealthy citizens.²

Food is an important and basic biological need of children. It is essential for life, growth and repair of the human body, regulation of body mechanism and production of energy for work. The nutrition of people on a global level is of great concern today particularly in developing nations.³ The World Health Organization defines malnutrition, “The cellular imbalance between supply of nutrients and energy and the body’s demand for them to ensure growth, maintenance, and specific function.”⁴

Mother's education can generate different types of intra household effects and thereby reducing the risk of nutritional deficiency like Protein-Energy Malnutrition. The effects which will bring through mothers’ education were; improved health and nutrition knowledge, psychological changes and improved nutritional behaviour, shift of power relations within the household in favour of better nutrition which includes breast feeding, weaning practices and

child feeding and pregnancy diets may lead to more effective dietary behaviour on the part of mother's who manage food resources within the household.⁵

Under –nutrition is widely recognized as a major health problem in the developing countries of the world. Severe protein energy malnutrition, often associated with infection contributes to high child mortality in hospital. Protein energy malnutrition is an important nutrition problem among preschool age children. Protein-energy malnutrition is a potentially fatal body-depletion disorder. Protein-energy malnutrition is measured in terms of underweight [low weight for age,] stunting [low height for age] and wasting [low weight for height]. A total 80% of the children affected live in Asia-mainly in southern Asia. Approximately, 43% of children [230 million] in developing countries are stunted. Efforts to accelerate significantly economic development will be unsuccessful until optimal child growth and development are ensured for the majority. High risk factor for malnutrition in, accounting for 58-65% of total calories and proteins consumed in 1999-2000. The worst performing states with underweight children under five years of age are Madhya Pradesh (60%), Jharkhand (56.5%) and Bihar (55.9%).⁶

LITERATURE REVIEW: Total 33 reviews were gathered which are drawn from various sources like database, articles, books and journal. The reviews were divided into three sections; review related to general information regarding nutritional status of children, studies related to causes and risk factors about protein energy malnutrition and reviews related to prevalence.

STUDY OBJECTIVES:

1. Assess existing knowledge regarding prevention and control of protein energy malnutrition among mother of children under five children.
2. Identify association between knowledge score and selected demographic variables.

MATERIALS AND METHOD:

In this study, the research design was descriptive one group pre-test design. The study was conducted at Paediatric OPD of Dhiraj Hospital, Vadodara. Mothers of under five year children were selected as a sample. Total sample size was 60 which were chosen by using purposive sampling technique.

Inclusion criteria

- Mothers of under five years children of who are willing to participate.
- Mothers of under five years children who are able to read Gujarati, Hindi or English.
- Mothers of under five years children who having age between 25-45 years.
- Mothers of under five years children who is attending Paediatric OPD.

Exclusion Criteria:

- Mother who are not available during the time of data collection.

Tool for data collection:

This consists of two parts:

Section 1: Social Demographic variables includes age of mother (in year), religion, type of family, occupation, education, monthly family income (in rupees), dietary pattern, number of children in the family, any previous knowledge regarding malnutrition.

Section 2: Structured Knowledge questionnaires related protein energy malnutrition was used to assess the knowledge of mother of under five years children.

Scoring procedure: For knowledge questionnaire, if answer is correct -1, if answer is incorrect-0

Scoring interpretation

Poor: - 1-10

Average: - 11-20

Good: - 21-30

Data collection procedure

Prior permission was obtained from the Medical superintendent of Dhiraj hospital. The data collection was done within a given period of 1 week, dated 2nd march to 5th march 2019. After a brief introduction of the self and establishing the rapport, the investigator has selected the sample with purposive sampling technique and gives a brief detail about the nature of the study and its purpose and mother of 0-5 year age of child who participates were given an information letter to read regarding the details of the study. Data was collected by using pre test knowledge questionnaire.

Statistical design

Data were verified prior to computerized entry. The Statistical Package for Social Sciences (SPSS version 20.0) was used. Descriptive statistics were applied (e.g., mean, standard deviation, frequency and percentages). Test of significance (chi square and paired t test) was applied to test the study hypothesis.

DISCUSSION:

This research establishes the importance of adequate knowledge regarding food pattern, antenatal care, social and psychological believe. Because maternal acquaintance can save the child from getting preventable problems like malnutrition. Mohammad Mohseni et al (2019) has conducted a study, they stated that; more attention should be paid to the shortage of some micronutrients, accurate implementation of breastfeeding programs, supplementary nutrition, fortification and supplementation programs for children and mothers, utilization of the advantages of each region and its resources, and better coordination between organizations and their policies, and finally strong incentives are needed to promote macro nutritional goals for children under five years of age. Chetan S Patali et al (2018) conducted descriptive study, which concluded that the education program should give importance to equip the mothers with adequate knowledge regarding nutrition there by prevention from threat of nutritional deficiencies. Ansuya Bengre et al (2018) conducted a systematic review and meta analysis the finding of this review indicate that malnutrition is still and important problem in children. there is a need for finding the risk factors for malnutrition and consistent effort from department and parents concerned to improved the notional status further to reduced morbidity among children.

FINDINGS:

SECTION: I

ASSESSMENT OF PRE- TEST KNOWLEDGE ON PROTEIN ENERGY MALNUTRITION

Table 1: Pre- Test Knowledge on Protein Energy Malnutrition.

N=60					
Sr. No.	Knowledge Aspects	Maximum Score	Mean	Mean %	SD
1	Introduction	5	2.1	42%	1.16
2	Causes	3	0.98	33%	0.59
3	Sign And Symptoms, Risk Factor, And Complication	13	5.9	45%	2.48
4	Diagnosis Evaluation	1	0.68	68%	0.47
5	Prevention And Management	8	3.41	43%	1.46

Above table reveals that the introduction comprises of 5 items had a mean of 1.2 with a standard deviation of 1.16 and mean % of 42%. Cause with 3 items had mean of 0.98 with 0.59 standard deviations and mean % of 33%. Sign And Symptoms, Risk Factor, And Complication with 13 items had mean of 5.9 with standard deviation of 2.48 and mean % of 45%. Diagnosis Evaluation had 1 item with mean of 0.68 with standard deviation of 0.47 and mean % of 68%. Prevention And Management of 8 items had means of 3.42 with standard deviation of 1.46 and mean % of 43%.

Table 2: Overall knowledge level in Pre Test

N=60		
SCORE	KNOWLEDGE	
	FREQUENCY	PERCENTAGE
Poor	13	22%
Average	47	78%
Good	0	0%

SECTION-2

FREQUENCY AND PERCENTAGE DISTRIBUTION OF DEMOGRAPHIC VARIABLES

The majority of samples 80% belong to 18-28 years of age. The highest percentages 86.70% of mothers are Hindu. Maximum mothers 48.33% are staying in Joint family. 63% of mothers are house wife. Maximum 50% of mothers are Secondary educated. 43.33% of mothers are having monthly family income above 9001. Maximum 53.33% of mothers are vegetarian, majority of 46.66% family have 2 Childs in family, and 93.33% of mother has no knowledge regarding malnutrition.

SECTION -3 ASSOCIATION OF THE PRE- TEST KNOWLEDGE SCORE AMONG MOTHER WITH THEIR DEMOGRAPHIC VARIABLE

Table 3: Association of the Pre- Test Knowledge Score among Mother with Their Demographic Variable
N = 60

Sr. No.	Variable		χ^2	df	Level of significance at 0.05 level
1	AGE OF MOTHER	18-28 years	0.40	2	5.99 NS
		29-38 years			
		39-49 years			
		Above 48			
2	RELIGION	Hindu	2.80	3	7.82 NS
		Muslim			
		Christian			
		Others			
3	TYPE OF FAMILY	Nuclear family	1.29	2	5.99 NS
		Joint family			
		Extended family			
		Single parent family			
4	OCCUPATION	Employed	4.57	3	7.82 NS
		Self employed			
		House wife			
		Unemployed			
5	EDUCATION	Illiterate	2.26	3	7.82 NS
		Primary education			
		Secondary education			
		Graduate			
6	MONTHLY FAMILY INCOME	Below 3000	13.81	2	5.99 S
		3001-6000			
		6001-9000			
		Above 9001			
7	DIETARY PATTERN	Vegetarian	3.34	2	5.99 NS
		Non vegetarian			
		Mixed			
8	NUMBER OF UNDER FIVE CHILDREN IN THE FAMILY	1	1.97	3	7.82 NS
		2			
		3			
		More than 3			

* Significant at 0.05 (95%) level

RESULT:

The result shown that majority participants, 78% have average knowledge related protein energy malnutrition, 22% have poor knowledge regarding protein energy malnutrition. The Chi Square test was used to identify association between knowledge score with selected demographic variable. Monthly income of family (13.99>5.99) significant at 0.05 level of significance, demographic variable i.e. age of mother, religion, type of family, occupation, education, dietary pattern, number of under five children in the family, and any previous knowledge regarding malnutrition were non - significant at 0.05 level of significant hence H_1 hypothesis is partially accepted.

RECOMMENDATIONS:

Based on finding of present study recommendation offered for the further study are:

- The similar study can be conducted on large sample
- A comprehensive study can be undertaken to see the difference between the rural and urban areas regarding prevention and control PEM.
- Regular health education programmes can be conducted by health personnel related to prevention and control.

CONCLUSION:

The present study assessed the existing knowledge regarding prevention and control of protein energy malnutrition among mother of less than five year children. According to the knowledge score of the mothers, found that maximum mother have average knowledge score regarding prevention and control of protein energy malnutrition. No one is having adequate knowledge on this subject. This suggests that awareness program regarding protein energy malnutrition is required to minimize the incidence.

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**“Effectiveness of health teaching programme on knowledge regarding
selected aspect of safe motherhood among primigravida of a selected
hospital”**

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Abstract :

Background: Each year in India, roughly 30 million women experience pregnancy and 26 million have a live birth. Maternal mortality is defined as the death of a woman during pregnancy, childbirth or within 6 weeks after birth. With an estimated 45,000 deaths per annum, In this study an quantitative research approach with pre-experimental research design was used to assess the effectiveness of health teaching programme on knowledge regarding selected aspect of safe motherhood among primigravida. **Material and method:** Quantitative research approach with pre-experimental one group pre-test post test research design is used. The non probability purposive sampling technique is used to collect the 60 samples of primigravida, attending obstetric OPD of Dhiraj Hospital and data collected by administering the structured knowledge questionnaire. Data was analyzed by using descriptive and inferential statistics such as standard deviation, chi-square test, and ‘t’ test. **Result:** The pre-test knowledge score depicted that, (38.33%) primigravida mother was having average level of knowledge and more than half of the participants (61.67%) were having poor knowledge, The post test score demonstrated there was increment in the knowledge, (76.66%) primigravida having good knowledge, one forth of primigravida (23.33%) was having average knowledge, nobody was found at the poor level. The obtained pre test mean score was 11.4 and after providing HTP, it increased up to 21.59, the mean difference of the pre test and post test is 10.19. The obtained ‘t’ test value 76.16, df = 59 shows significant at 0.05 level, which indicates that, there is significant difference between pre test and post test knowledge level regarding selected aspect of safe motherhood after providing HTP. So H₁ is accepted. Hence, conclude that there is significant difference between pre test and post test knowledge. The pre-test knowledge score with socio demographic variable is only associated with occupation of primigravida and others were not. Hence, H₂ is rejected.

Key Words: Effectiveness, Knowledge, Selected Aspect of Safe Motherhood, Primigravida.

INTRODUCTION:

Global aim of safe motherhood is “to improve well being of mother through a comprehensive approach of providing, preventive, promotive, curative and rehabilitative health care. Safe motherhood objective are improve quality and increase access to family planning and maternal health care services educate couples to ensure they have the best chances for a wanted and safe pregnancy to promote improvement of system for morbidity maternal and newborn health services.¹ To promote the implementation of evidence based integrated cost effective reproductive health intervention with a focus on maternal and newborn health within primary health care approach.² “Safe motherhood means creating the circumstances within which a women is able to choose whether she becomes pregnant⁶ and If she does ensuring that she receives care for prevention and treatment of pregnancy complications that she has access so skill birth attendances and if she needs if to emergency obstetric care and after birth to prevent death and disability from”³ India contributes to a majority of maternal mortality burden in the region which can be reduce by ensuring the appropriate knowledge and health care services. Safe motherhood means ensuring that all women have access to the information and service they need to go safely through pregnancy and child birth.⁴

LITERATURE REVIEW: In this study reviewer has reviewed total 50 review of literature which is gathered from various sources including articles, journals, various database, thesis and books and presented under the following headings:

Section-A: Literature related to knowledge regarding antenatal care and utilization of antenatal care

Section-B: Literature related to antenatal check-up

Section-C: Literature related to immunization

Section-D: Literature related to knowledge regarding antenatal diet and dietary Patten.

STUDY OBJECTIVES:

1. Assess the pre existing knowledge of Primigravida regarding selected aspect of safe motherhood.
2. Find out the effectiveness of HTP.
3. Find out the association of pre test knowledge score regarding selected aspect of safe motherhood with Socio-demographic variables.

HYPOTHESES:

H₁: There will be significant difference between the pre-test and post test knowledge score of Primigravida regarding selected aspect of safe motherhood

H₂: There will be significant association between the knowledge of Primigravida mothers regarding selected aspect of safe motherhood with selected demographic variables.

MATERIALS:

A structured knowledge questionnaire developed to assess the effectiveness of health teaching programme regarding selected aspect of safe motherhood. The tool consisted of Section-A and Section-B. Section-A consisted the demographic variables includes, age, religion, education, type of family, age of marriage, family income, occupation, trimester. Section-B consisted of structured knowledge questionnaire on selected aspect of safe motherhood.

METHOD:

Quantitative research approach with pre- experimental one group pre-test post test research design is used. The non probability purposive sampling technique is used to collect the 60 samples of primigravida, attending obstetric OPD of Dhiraj Hospital, Vadodara.

DISCUSSION:

The findings of the study were discussed with reference to the objectives and hypothesis stated in the section of findings. The present study was undertaken 'To assess the effectiveness of health teaching programme on knowledge regarding selected aspect of safe motherhood among primigravida of a selected hospital. Findings of the study are supported by a study done to assess the effectiveness of Health Teaching Programme on safe motherhood shows positive impact of providing HTP with promoting the utilization of obstetric care and a skilled attendant at delivery.⁵

- A cross-sectional study carried out Knowledge of safe motherhood among women showed poor knowledge of the benefits of health facility researcher stated that acquiring some level of education will help to increasing knowledge about safe motherhood practices, so health education programmes by various health workers need to be conducted.⁶
- An experimental study conducted to assess the effectiveness of structured teaching programme among primigravida shows lack of knowledge but after proving STP its was significantly increased.⁷
- A study was conducted to evaluate a health education programme provided to primigravida in the third trimester of pregnancy with the aim to improve the knowledge of 60 mothers in. Results suggest that the knowledge rate after the intervention has significantly increased regarding aspect of safe motherhood.⁸

ANALYSIS:

Analysis of this study presented under various sections with following headings:

Section - A: Description of samples according to their demographic characteristics.

Section - B: Analysis of pre test and post test score of knowledge regarding selected aspect of safe motherhood.

Section - C: Effectiveness of health teaching programme.

Section - D: Association between pre test knowledge score with socio-demographic variable

FINDINGS:

Socio- demographic finding: Majority of (61.66%) primigravida mothers were in the age group of 23-27 years and minimum (8.34%) were in the group of 28-32 and 32-35. (21.66%) in the age group of 18-22 yrs. The highest percentage of primigravida belongs to Hindu Religion (68.33%) and (10%) were Muslim, (8.34%) were Christian, (13.33%) belongs to other category. (51.67%) of primigravida mothers were educated only upto 10th standard, (25%) of primigravida were illiterate, (8.33%) primigravida were Post graduate (15%) were graduated. Maximum (65%) of primigravida belongs to the joint family and (35%) of primigravida belongs to the nuclear family. highest percentage (56.66%) of primigravida mother were married in the age of <20 maximum percentage and (33.34%) of primigravida mother married were in age of 20-24 and lowest percentage (10%) of primigravida mother were married in the age group of 25-29. Majority of primigravida were having family income (43%) in the range of 10,000-20,000, (15%) primigravida were below 5000, (41%) in the range of 5000-10,000, and only (1%) were primigravida having above 20,000-30,000 family income per month. Majority (58.33%) were house wife and (26.67%) were having other profession and (15%) were having health professional. Majority (46.67%) of mothers were in 1st trimester, (33.33%) of mother in 2nd trimester and only (20%) of mother were in 3rd trimester.

Pre existing knowledge of Primigravida regarding selected aspect of safe motherhood:- Out of 60 primigravida mothers (61.67%) had poor knowledge, (38.33%) had average knowledge and none of respondent was in the category of good knowledge.

Effectiveness of health teaching programme: Table: 1- Comparison of pre test and post test knowledge score of primigravida mother.

N=60

Significant at 0.05 level

*t (0.05, 59df) =2

Association between pre test knowledge score of the primigravida with selected socio-Demographic variable:

Variable	Test	Mean	Mean difference	Std. Deviation	T value
Knowledge regarding selected aspect of safe motherhood	Pre test	11.4	10.19	7.7	35.93
	Post test	21.59		7.28	

Table 02: Association between pre test knowledge score and socio-demographic variables

N=60

Sr no	Variable	1-10	11-20	χ^2	D.F	level of significances
1	Age in Years					
	18-22	6	7	0.087	3	0.087 < 7.82 NS
	23-27	16	21			
	28-32	2	3			
	32-35	2	3			
2	Religion			0.926	3	0.926 < 7.82 NS
	Hindu	18	23			
	Muslim	2	4			
	Christiam	3	2			
	Other	3	5			
3	Education			2.818	3	2.818 < 7.82 NS
	Illiterate	9	7			
	up to 10	13	18			
	Graduate	2	7			
	post graduate	2	2			
4	Type of family			0.687	1	0.687 < 3.84 NS
	Nuclear	8	14			
	Joint	18	23			

5	Age of marriage			0.866	2	0.866<5.99 NS
	<20	16	18			
	20-24	7	13			
	25-29	3	3			
6	Family income monthly			0.802	2	0.802<5.99 NS
	Below 5000	4	4			
	5000-10000	12	13			
	10000-20000	10	17			
	20000-30000	0	0			
7	Occupation			6.295	2	6.295<5.99 S
	House wife	19	12			
	Health professional	2	15			
	Other occupation	5	7			
8	Trimester			0.923	2	0.923<5.99 NS
	1st Trimester	12	19			
	2nd Trimester	9	8			
	3rd Trimester	5	7			

Significant at 0.05 level

*S=Significant

χ^2 = Chi Square

* NS= Non Significant

RECOMMENDATIONS: Based on the findings of the present study recommendation offered for the future study:

- The similar study can be conducted on larger sample this will help to generalised the result among population
- A similar study can be done to assess the knowledge and practice regarding selected aspect of safe motherhood.
- The similar study can be done in the community setting.

CONCLUSION: One of the factors contributing to the maternal mortality is lack knowledge on selected aspect of safe motherhood so it essential that health care provider should impart among the population which will help to prevent future consequences among the mother and infant. This study was undertaken to assess the effectiveness of health teaching programme regarding selected aspect of safe motherhood involves one group pre-test post-test pre experimental design with non probability purposive sampling technique, 60 samples of primigravida was selected on the basis of inclusion and exclusion criteria. The findings of the study shows that there is need to improve the knowledge regarding aspect of safe motherhood and the various educational programme will help to impart the appropriate knowledge among the mothers, this can be achieved by ensuring the more empirical studies on the safe motherhood. The health care workers will have to take lead in relation to improve the maternal and infant health by providing education and health services to maintain the safe motherhood.

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“A study to assess effectiveness of planned teaching programme on precaution while handling bio-medical waste among class-IV workers, working in Dhiraj hospital at Vadodara.”

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Abstract: BACKGROUND: The Bio-Medical waste may pose an occupational hazard when managed incorrectly. Therefore, we need special precautions and the well-trained personnel to manage those biomedical wastes and keep the risk low. So it is important to enhance knowledge regarding precaution while handling BMW among the Class IV workers. In this study Quantitative evaluative research approach with pre experimental one group pre-test, post-test research design was used. **MATERIAL AND METHOD:** In this research study Quantitative evaluative research approach with pre- experimental one group pre-test-post-test design was used. The sampling technique was non probability convenient sampling used to collect the 60 samples of Class IV workers. Data collection was done by administering the self structured questionnaire. Data was analyzed by using descriptive and inferential statistics such as standard deviation, chi- test, and paired ‘t’ test. **RESULTS:** The findings shows that there is no significant association between knowledge of Class IV workers and selected demographic variable. The pre test mean score of knowledge of Class IV workers was 12.97 (43.23%) and post test mean score of knowledge was 21.51 (71.7%). The mean difference of pre and post test knowledge score was 8.54 which show the effectiveness of Planned Teaching Programme. The calculated value of ‘t’ test was (62.89) at 0.05 level of significance, which was more than table value of ‘t’, Therefore Finding reveals the planned teaching programme was effective to increase the knowledge of respondent Hence, H₁ is accepted and another finding reveals there was no significant association between pre test knowledge score with demographic variable of age, education, experience & previous exposure. Hence hypothesis H₂ is rejected. **CONCLUSION:** In this study found that post-test knowledge score is higher than the pre-test score. So, it indicate effective outcome of planned teaching programme on Precaution while handling Bio-medical waste among Class IV workers. Pre-test knowledge score were not associated with selected demographical variables.

Key Words: Effectiveness, Planned Teaching Programme, Class IV workers, Bio- Medical Waste Management.

INTRODUCTION:

Bio-medical waste may be very hazardous if it's not disposed of in the right way. Universal precautions are used in all instances of medical waste disposal. Blood and blood products are always considered potentially infectious and are treated as such. The health hazard concern regarding medical waste began in the 1980s when medical objects like needles started to wash up on many east coast beaches. Great strides in proper medical waste disposal have been made since then.¹

Epidemiological studies indicate that a person who experiences one needle-stick injury from a needle used on an infected source patient has risks of 30%, 1.8%, and 0.3% respectively to become infected with HBV, HCV and HIV. In 2002, the results of a WHO assessment conducted in 22 developing countries showed that the proportion of healthcare facilities that do not use proper waste disposal methods ranges from 18% to 64%.²

WHO (World Health Organization) even mentioned that in 2000, there were 32% new Hepatitis B infections due to improper way of contaminated syringe disposal. In 2002, WHO conducted a research to review 22 countries

about their way of medical waste disposal management and resulting various ranges from 18% up to 64% that used *improper methods* of biomedical waste management. Which is dangerous for people who have the highest risk of being the biomedical waste, for instance, healthcare workers, patients, waste collection and disposal staff, and even our environment. The biomedical waste may pose an occupational hazard when managed incorrectly. Therefore, we need special precautions and the well-trained personnel to manage those biomedical wastes and keep the risk low.³

LITERATURE REVIEW:

A study was conducted by **Parvin Lakbala, Farbood Ebadi Azari et.al 2012**, on Needle sticks and sharps injuries among housekeeping workers in hospitals of Shiraz, Iran. For the effective prevention of these injuries, health boards and hospital trusts need to formulate strategies to improve the working conditions of health care workers, discourage the excessive use of injections, and increase their adherence to universal precautions.⁴

A study was conducted by **P.V. Srinivasa Kumar, P. Padmaja et.al (2017)** on Knowledge, Attitude, Practices of Biomedical Waste Management among Nursing Students and Staff in a Tertiary Care Hospital. The result of study is Third year students answered better than first year and second year students towards KAP of Bio Medical Waste management. Out of 54 third year students, 88.8% gave correct answers to knowledge questionnaire, 79.6% and 74% responded well to attitude and practice questionnaire. Out of 147 nursing students, 14.2% of first year, 21.7% of second year, 32.6% of third year students gave correct answers to knowledge questionnaire. And study is concluded as the higher education and clinical rounds are needed for nursing students to increase the knowledge of bio medical waste management activities.⁵

STUDY OBJECTIVES :

- ❖ Determine the knowledge regarding precaution while handling biomedical waste among class-IV workers of selected hospital.
- ❖ Assess the effectiveness of planned teaching programme regarding precaution while handling bio-medical waste.
- ❖ Find out the association between the pre-test knowledge score regarding precautions while handling bio-medical waste with their selected demographic variables.

MATERIALS:

Research variables

- ❖ **Independent variables:** The independent variable in this study is planned teaching programme on precaution while handling biomedical waste.
- ❖ **Dependent variable:** The dependent variable in this study is knowledge regarding precaution while handling bio-medical waste among class-IV workers.
- ❖ **Socio-demographic variable:** The socio-demographic variables in this study are age, education, working experience in hospitals, previous exposure of Bio-Medical Waste.

Description of tools

This consists of two parts:

- ❖ **Section 1:** Deals with the demographic data of the samples such as Age, Educational Qualification, Working experience in hospitals & Previous Exposure regarding Bio Medical Waste Management.
- ❖ **Section 2:** It Consisted of a 30 multiple choice questionnaire (MCQs) to assess the Knowledge of Class IV workers working in Dhiraj Hospitals at Vadodara regarding Bio- Medical Waste Management.

Scoring Procedure:

- ❖ For knowledge assessment If answer is right then give - **1**
If the answer is wrong then give - **0**

Scoring Interpretation Of Knowledge:

- ❖ Adequate knowledge: **≥67%** in Score (21-30)
- ❖ Moderately adequate knowledge: **34-66%** in Score (11-20)
- ❖ Inadequate knowledge: **≤ 33%** in Score (<10)

Reliability

The reliability of tool established by using split half method 'Spearman Brown Prophecy formula' (r=0.86) reliability test.

METHOD:

Research design:

- ❖ In this study, the research design was pre-experimental one group pre-test post-test research design.

Setting

- ❖ In this research study setting refers to Dhiraj hospital, Piparia, Waghodiya Vadodara.

Sample

- ❖ The sample for this study Comprise of 60 Class IV workers belongs to Dhiraj Hospital and available during the research study.

Method of data Collection

- ❖ Self administrated questionnaire on precaution while handling Bio-Medical Waste.

Inclusion Criteria: -

- ❖ Available at the time of data collection.
- ❖ Willing to participate in the study.

Exclusion Criteria:-

- ❖ The study excludes the class-IV workers who Can't read and write Gujarati.

DISCUSSION:

The aim of the study was conducted to evaluate the effectiveness of PTP on knowledge regarding precaution while handling BMW among Class IV workers. It was found Class IV workers had inadequate knowledge regarding precaution while handling BMW and PTP is effective to improve the knowledge and bring a good knowledge towards precaution while handling BMW.

Various evidences show the effectiveness of PTP in improving knowledge regarding precaution while handling BMW. the Class IV workers are having lack of knowledge regarding precaution while handling BMW, so it is important that health care provider should provide the knowledge regarding precaution while handling BMW.

ANALYSIS:

TABLE 1: Frequency and percentage distribution of samples, according to their demographic characteristic N=60

SR.NO	CHARACTERISTICS	FREQUENCY	PERCENTAGE
1.	Age in years		
	a) 20-30	16	26.6%
	b) 31-40	30	50%
	c) 41-50	14	23.3%
2.	Education status		
	a) Below 8 th Std.	21	35%
	b) Above 8 th Std.	39	65%
3.	Year of job experience		
	a) 1 year	16	26.66%
	b) 2 year	13	21.66%
	c) 3 year	14	23.33%
	d) More than 3 year	17	28.33%
4	Previously Exposure Regarding BMW management.		
	a) Yes	54	90%
	b) No	6	10%

TABLE 2: Distribution of Mean, SD and mean percentage of pre test knowledge Score of Class IV workers. N=60

Sr.no	Knowledge Aspect	Maximum	Mean	Mean %	SD
1.	Introduction	5	3.40	68%	1.06
2.	Sources	2	0.48	24%	0.65
3.	Type & Colour of BMW	9	3.38	37.55%	1.57
4.	Potential Hazards & Its Prevention	8	3.61	45.12%	1.41
5.	Segregation & collection of BMW	4	1.30	32.5%	0.88
6.	Role of Class IV workers	2	0.80	40%	0.73
	Overall score	30	12.97	43.23%	6.3

Table 3: Association between pre test knowledge score and socio-demographic variables N=60

Sr. no.	Variable	0-10	11-20	Total	X ²	df	Level of significance
1	AGE				3.017	2	3.017<5.99 NS
	20-30	02	14	16			
	31-40	04	25	29			
	41-50	05	10	15			
	TOTAL	11	49	60			
2	EDUCATIONAL STATUS				3.24	1	3.24<3.84 NS
	BELOW 8 th STD.	6	13	19			
	ABOVE 8 th STD.	5	36	41			
	TOTAL	11	49	60			
3	YEAR OF EXPERIENCE				1.59	3	1.59<7.81 NS
	1 YEAR	03	12	15			
	2 YEAR	01	13	14			
	3 YEAR	03	11	14			
	>3 YEAR	04	13	17			
	TOTAL	11	49	60			
4	PREVIOUSLY ANY EXPOSURE BMW PROGRAMME				0.127	1	0.127<3.84 NS
	Yes	10	46	56			
	No	01	03	04			
	TOTAL	11	49	60			

FINDINGS:

Section A: Description of samples according to their demographic characteristics.

- ❖ The highest percentage (50%) of Class IV workers were in the age group of 31-40 years and least (23%) of Class IV workers were in the age group of 41-50 years. (26%) of Class IV workers were indicated in age of 20-30 years.
- ❖ The highest number (65%) of Class IV workers were Above 8th Std and lowest number (35%) of Class IV workers were Below 8th Std.
- ❖ Most of the participant (28%) have more than 3 years of experience remaining Class IV workers (27%) have 1 year and (23%) have 3 years of experience and least of Class IV workers (18 %) have 2 years of experience in hospitals.
- ❖ 90% of Class-IV workers having previous exposure of BMW programme, least of (10%) not having previous exposure regarding BMW programme.

Section B: Analysis of pre test and post test score of knowledge Regarding Precaution while handling BMW.

Table 1: Distribution of pre test and post test knowledge score according to the percentage N=60

Sr. No	Categories of knowledge score	Percentage	Pre test	Post test
1	Inadequate	<33%	18.3%	0%
2	Moderate	34-66%	81.7%	35%
3	Adequate	>67%	00	65%

Section C: Effectiveness of Planned Teaching Programme.

Table 2: Comparison between pre test and post test score of knowledge among Class IV workers regarding precaution while handling BMW. N=60

Variable		Mean	Mean Difference	Std. Deviation	t- Value
Knowledge regarding precaution while handling BMW.	Pre-test	12.97	8.54	6.30	62.89
	Post-Test	21.51		5.32	

* Significant at 0.05 level

*t (0.05, 99df) = 2

Section D: Association between pre test knowledge score with socio demographic variables.

Association between pre test knowledge score and socio-demographic variables

- ❖ Finding data reveals that association between knowledge of Class IV workers and demographic variable. There are no any significant demographic variable. All of the above variables are non-significant.
- ❖ Hence, research hypothesis H_2 was not accepted.

RESULT:

The findings shows that there is no significant association between knowledge of Class IV workers and selected demographic variable. The pre test means score of knowledge of Class IV workers was 12.97 (43.23%) and post test mean score of knowledge was 21.51 (71.7%). The mean difference of pre and post test knowledge score was 8.54 which show the effectiveness of Planned Teaching Programme. The calculated value of 't' test was (62.89) at 0.05 level of significance, which was more than table value of 't', Therefore Finding reveals the planned teaching programme was effective to increase the knowledge of respondent Hence, H_1 is accepted and another finding reveals there was no significant association between pre test knowledge score with demographic variable of age, education, experience & previous exposure. Hence hypothesis H_2 is rejected

RECOMMENDATIONS:

Based on the findings of the present study recommendation offered for the future study:

- ❖ The similar study can be conducted in different settings.
- ❖ The similar study can be conducted on all health care personal.
- ❖ The similar study can be conducted in more depth.
- ❖ The similar study can be conducted in large sample.
- ❖ The similar study can be conducted in different hospital.

CONCLUSION:

The analysis reveals that the total mean of post-test knowledge score was observed to be significantly higher than the total mean of pretest knowledge score after providing PTP to the Class IV workers regarding precaution while handling BMW. Hence, it is concluded that the PTP was effective to increase the knowledge regarding the precautions while handling BMW. Education regarding Bio-medical Waste Management should be given to all Class IV workers to improve their knowledge of procedure which may aid in reducing rate of infection and needle stick injury.

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“A study to assess knowledge regarding ayushman bharat yojana among people visiting dhiraj hospital Vadodara.”

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Abstract:

BACKGROUND: Ayushman bharat yojana is a new centrally sponsored scheme launched in 2018, under the Ayushman Bharat Mission of Ministry of Health and Family Welfare in India. The scheme aims at making interventions in primary, secondary and tertiary care systems, covering both preventive and promotive health, to address healthcare holistically. And Identify association between knowledge score and selected demographic variables. In this study quantitative evaluative research approaches with Descriptive Research Design. It is used helps in collecting data, analyzing data.

METHOD: In this research study a quantitative research approach with descriptive survey research design is used. The sampling techniques was non probability convenience sampling is used to collect the 100 samples of people visiting Dhiraj Hospital and Data collection done by administering the structured questionnaire. Data was analyzed by using descriptive and inferential statistics such as standard deviation, chi- test.

RESULT : With regards to the pre test assessment, the score was 14(14%) sample had poor knowledge on Ayushman Bharat Yojana. 86(86%) samples had average level of knowledge on Ayushman Bharat Yojana. nobody was found at good knowledge ,So this indicates sample having deficit knowledge regarding Ayushman Bharat Yojana. The obtained pre test mean score was 14.3 The pre-test standard deviation was 4.10592. So we accept H₁ partially.

CONCLUSION: The findings of the study concluded that majority of people were having average level of knowledge regarding Ayushman bharat yojana.

Key Words

Assess, Knowledge , Ayushman Bharat Yojana

INTRODUCTION:

The global community faces a double challenge: significant parts of the world's population still lack access to even the most basic medicines. And still, health care costs the financial burden on societies and individuals continue to rise. Sandoz's own research on global access to healthcare has led us to group these challenges into three district areas. They believe that all societies need to: Build medical capacity, Increase access to medicine, Improve access to medical information. They believe that each of these challenges' demands a unique approach. And each approach must be multifaceted, because societies must search for solutions on several levels.¹In India, Indians have registered a 50% increase in the prevalence of ischemic heart disease and strokes over a period from 1990 to 2016, with the number of diabetes cases climbing from 26 million to 65 million. In the same period chronic obstructive lung disease went up from 28 million to 55 million , the proportional contribution of cancer to the total health in India has doubled from 1990 to 2016, but the incidence of different types of cancer varies widely between states.²

A number of studies have revealed that risk owing to low level of health security is endemic for informal sector workers. The vulnerability of the poor informal worker increases when they have to pay fully for their medical care with no subsidy or support. On the one hand, such a worker does not have the financial resources to bear the cost of medical treatment, on the other; the health infrastructure leaves a lot to be desired. Large numbers of people,

especially those below poverty line, borrow money or sell assets to pay for the treatment in private hospitals. Thus, Health Assurance could be a way of overcoming financial handicaps, improving access to quality medical care and providing financial protection against high medical expenses.³

LITERATURE REVIEW:

Priyanka Jalal (2018) a descriptive study at lunkaransar block of Bikaner district of Rajasthan to assess the knowledge about Mid Day Meal scheme which was selected by lottery method. Aiming at improving nutritional status and school enrolment which was launched as a centrally sponsored programme. Sample size is 200 students study in sixth, seventh and eight classes 50 parents and 30 teachers which were selected randomly. The study revealed that majority of school children (78.5%), parents (80.0%), and teachers (70%) had medium level of knowledge about mid day meal scheme whereas maximum number of respondents had less knowledge about year of state, dietary requirement of the children per day and revised guideline of government of India. It conclude that majority of school children, parents and teacher belongs to medium level of knowledge regarding mid day meal scheme.⁴

Neha Ande (2017) a cross sectional study to assess the knowledge and attitude of antenatal and postnatal mothers about Janani Suraksha Yojana at tertiary care hospital Bharti hospital in Pune city. A structured questionnaires in local language was used and information collected by interview method. Out of 65 participants 45 (69.23%) were not aware about the yojana only 20 (30.76%) participants has knowledge about this yojana. 15 (75%) had received information about this yojana from television and newspaper and 5 (25%) participants were informed by ASHAs. This study received that inadequacies in knowledge of antenatal and postnatal mothers regarding this yojana however, positive attitudes were found in those mothers who were aware about this scheme.⁵

Subhashini Revu (2017) an observational study to assess the impact of Janani Shishu Suraksha Karyakram Scheme on institutional delivery in Visakhapatnam district with objective to assess the impact of JSSK on institutional deliveries, maternal mortality and morbidity and find out drawback in the implication of this scheme especially among target population. Total 464 delivered women during this period were given structured questionnaires. In that, 87.8% of delivered women in vishakhapattanam hospital. 98.9% expressed their satisfied with the service at VGH. It concludes that pregnant women die in India due to a combination of important factor like poverty, unaffordable health care services. Maternal mortality rate and infant mortality rate high found because of lack of awareness.⁶

STUDY OBJECTIVES:

1. To assess the perception and attitude of primary school teachers towards delinquent children.
2. To correlate the perception and attitude of primary school teachers towards delinquent children.
3. To find out the association between perception and attitude among primary school teachers towards delinquent children with their selected demographic variables.

MATERIALS:

Section 1:- Demographic data which include age, gender, qualification, occupation, types of family, currently holding any government scheme, family monthly income, heard about Ayushman Bharat Yojana, family member working in health sector.

Section 2:- Self structured knowledge questionnaires was used which included 30 questions regarding Ayushman Bharat Yojana.

METHOD:

In this study Quantitative research approach was used and descriptive research design was used. The data collection procedure was conducted, from 22 April 2019 to 26 April. Before data collection permission was obtained from Medical superintendent, Dhiraj Hospital for study conduction. Ethical clearance was obtained from Sumandeep Vidyapeeth Institutional Ethical Committee and individual consent was taken from each participants. A total of 100 samples were collected among people visiting Dhiraj Hospital.

DISCUSSION:

The present study was conducted to assess the knowledge regarding Ayushman bharat yojana among people visiting Dhiraj hospital. In order to achieve the objectives of the study, a descriptive designed was adopted. Non probability convenience sampling technique was used in practice. The data was collected from 100 respondents by using self structured knowledge questionnaires.

ANALYSIS:

Section 1: Analysis and interpretation of demographic variable

This section deals with the description of demographic characteristics of people visiting Dhiraj hospital and has been presented in the form of frequency and percentage. The demographic data section comprised 9 items

Table: 1 frequency and percentage distribution of samples, according to their demographic characteristics

SR.NO	VARIABLE	CATEGORY	FREQUENCY	%
1	Age	<15	0	0%
		16 To 25yr	22	22%
		Above 25yr	78	78%
2	Gender	Male	39	39%
		Female	61	61%
3	Educational status	Illiterate	13	13%
		Secondary	55	55%
		Higher Secondary	15	15%
		Graduate	17	17%
4	Type of family	Nuclear	44	44%
		Joint	56	56%
5	Family income monthly	Below 5000	22	22%
		6000 - 10,000	37	37%
		11,000-20,000	33	33%
		21,000-30,000	6	6%
		Above 31,000	2	2%
6	Occupation	Government Employee	4	4%
		Labourer	9	9%
		House Hold Work	42	42%
		Private Job	28	28%
		Self Employed	17	17%
7	Previous used of Yojana	No Use	32	32%
		Rashtriya Swasthya Bima	36	36%
		Mama Card	17	17%
		Janani Suraksha	12	12%
		Others	3	3%
8	Heard about Ayushman	Yes	78	78%
		No	22	22%
	If yes, through	Radio	21	21%
		Television	12	12%
		Newspaper	7	7%
		Friends	36	36%
9	Family member working with health sector	Yes	20	20%
		No	80	80%

Table 1 shows that majority of the people, 78 (78%) were above the 25 year of age and 61 (61%) female and 39 (39%) were male. 55(55%) had secondary education, 56(56%) belonged to joint family and 44 (44%) were belonged to nuclear family. Most of the participants 37 (37%) had monthly income were 6000-10,000 and majority 42(42%) belonged to household work as occupation. Most participants 36 (36%) were using Rashtriya Swasthya Bima Yojana Most participants 78 (78%) had heard about Ayushman bharat Yojana mostly through their friends (36%).

Table2: Knowledge score of people regarding Ayushman bharat yojana

[N=100]

KNOWLEDGE SCORE	FREQUENCY	PERCENTAGE (%)
Poor	14	14
Average	86	86
Good	0	0

This table shows that out of 100 participants 14% had poor knowledge regarding Ayushman Bharat Yojana, 86% had average and none had good knowledge regarding Ayushman bharat yojana.

Table: 3 Association between selected demographic variable and level of knowledge.

Sr. No.	Variable		Chi Square Value	Degree Of Freedom	Level of significance at 0.05 level
1	Age of people	<15 YEAR	1.254	1	1.254<3.84 NS
		16-25 YEARS			
		<25 YEARS			
2	Gender	Male	1.832	1	1.832<3.84 NS
		Female			
3	Educational status	Illiterate	48.115	3	48.115>7.82 S
		Secondary			
		Higher secondary			
		Graduates/masters			
4	Type of family	Joint	1.707	1	1.707<3.84 NS
		Nuclear			
5	Family income monthly	Below 5000	7.111	4	7.111<9.49 NS
		6000 - 10,000			
		11,000-20,000			
		21,000-30,000			
		Above 31,000			
6	Occupation	Government Employee	2.439	4	2.439<9.49 NS
		Labourer			
		House Hold Work			
		Private Job			
		Self Employed			
7	Previous used of Yojana	No Use	4.701	4	4.701<9.49 NS
		Rashtriya Swasthya Bima			
		Maa Card			
		Janani Suraksha			
		Others			
8	Heard about Ayushman Bharat Yojana	Yes	1.254	1	1.254<3.84 NS
		No			
	If yes,	Radio	2.365	3	2.365<7.82 NS
		Television			
		Newspaper			
		Friends			
9	Family member working with health care sector	Yes	5.502	1	5.502>3.84 S
		No			

*Significant at 0.05 level

NS-Non Significant

Above table depicts that the chi square is used to identify association between selected demographic variables and level of knowledge. According to demographic variable of people's educational status is significance at 48.115 level and people working with health care worker significant at 5.502 levels. So the H1 hypothesis in this study is partially accepted.

RECOMMENDATIONS:

- The similar study could be carried out on a large sample to generalize the findings
- A similar study can be performed in community setting.

CONCLUSION: The findings of the study have been discussed with reference to the objectives, hypothesis, and with the findings of other studies. Majority of people 86% samples have average level of knowledge on Ayushman Bharat Yojana. 14% participants have poor knowledge regarding Ayushman bharat Yojana. The chi square is used to identify association between selected demographic variables and level of knowledge regarding Ayushman bharat Yojana. This is association between level of knowledge and participants' educational status, working with health worker at 0.05 level of significance.

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**“Assess the Knowledge and Attitude Regarding Electro Convulsive
Therapy among Family Members of Clients Attending the Psychiatric
Out Patient Department in Mental Hospital Ahmedabad City”**

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Background: The standards of mental health are less clear than those of mental illness. Viewing mental health as a average or mean mental state of a group of problematic because what is average is not necessarily healthy. The **AIM** of my study is to Assess The Knowledge And Attitude Regarding ELECTRO CONVULSIVE THERAPY Among Family Members Of Clients Attending The Psychiatric OUT PATIENT DEPARTMENT. **Material and Method:** Descriptive survey research design, and non-probability purposive simple random sampling technique was adopted. The tool used for data collection was structured Knowledge questionnaire and Attitude likert scale. Sample size was 50 samples in the selected hospitals at Delhi darwaja Ahmedabad city of Gujarat state. **Conclusion:** 12% samples have good knowledge regarding Electro convulsive therapy, 76% samples have average knowledge and 08% have poor knowledge of Electro convulsive therapy. 52% samples have negative attitude towards electro convulsive therapy and 48% samples have positive attitude towards electro convulsive therapy.

Key words: Knowledge, Attitude, Electroconvulsive therapy, Family members.

INTRODUCTION:

Electroconvulsive therapy is a safe cost effective and useful treatment of mental illness and there is also a lack of knowledge misconception and ignorance regarding Electroconvulsive therapy not only among public. Even among the population of mentally ill patients and their relatives. Though Electroconvulsive therapy commonly used for mentally ill patients. The term Electroconvulsive therapy has not become very popular among patient and public instead of term the Electroconvulsive therapy common which are popular among is shock. So, the word shock its self is shocking to patient and family members.

They also think that is unite as a result in it cause different level of attitude and fear among family and patients. Even today majority of patient taken to temples, wizards and faith healers and very few of them realized that it is a type of illness and considered the treatment of mental illness by psychiatrist is required. Electroconvulsive therapy is only form of shock treatment still perform by medicine. The use of Electroconvulsive therapy

LITERATURE REVIEW:

The literature reviewed has been presented under the following categories.

Section: A: Studies on knowledge and attitude of family members on electro convulsive therapy.

Section: B: Studies on knowledge and attitude of mentally ill persons on electro convulsive therapy

STUDY OBJECTIVES:

- To assess the knowledge of family members regarding Electro Convulsive Therapy, attending psychiatric O.P.D in selected hospitals of ahmedabad city.
- To assess the attitude of family members regarding Electro Convulsive Therapy, attending psychiatric O.P.D in selected hospitals of ahmedabad city.

HYPOTHESES:

H₁: There will be significant association between the knowledge of family members regarding Electro Convulsive Therapy, attending psychiatric O.P.D and selected demographic variables.

H₂: There will be significant association between the attitude of family members regarding Electro Convulsive Therapy, attending psychiatric O.P.D and selected demographic variables.

MATERIALS:

A structured knowledge questionnaire and Attitude Likert rating scale used to assess the knowledge and attitude of family members on electroconvulsive therapy. The tool consisted of Section-A, Section-B and Section-C Section-A consisted the demographic variables Section-B consisted of structured knowledge questionnaire. And Section C consisted the Attitude Likert scale.

METHOD:

Quantitative research approach with descriptive research design is used. The non probability purposive sampling technique is used to collect the 50 samples of family members regarding Electro Convulsive Therapy, attending psychiatric O.P.D

DISCUSSION:

The data were analyzed and interpreted in terms of objectives of the study. Descriptive statistics were utilized for the data analysis. Data were organized and presented in following manner finding on description of data of samples, knowledge and attitude of relatives of samples regarding Electro Convulsive Therapy.

ANALYSIS:

Analysis of this study presented under various sections with following headings:

SECTION 1: its deals with the frequency the frequency percentage distribution of the demographic characteristics of the sample.

SECTION -02: It deals with frequency percentage distribution of knowledge level of the sample.

SECTION 3: It deals with analysis of attitude of the relatives regarding electro convulsive therapy.

FINDINGS:

Socio- demographic finding: out of 50 samples 05(10%) samples were in the age group of 20-30 years 11(42%) samples were in the age group of 31-40 years, 14(28%) samples were of 41-50 years, 10(20%) of 51 years and above. In gender 29(58%) samples were of male, and 21(42%) samples were female. In religion, 45(90%) samples were of Hindu, 5(10%) samples were of Muslim, no samples were from Christian and other religion. In marital status, 43(86%) samples were married, 7(14%) samples were Unmarried. In education qualification, 16(32%) samples were illiterate and 31(62%) samples were studied up to 12th, 03(06%) samples were graduate, and no sample were completed post graduation or above. In occupation, 03(06%) samples were student, 31(62%) samples were of employed / business, 15(30%) samples were of unemployed, 01 (02%) samples were of retired/ pensioners. In previous exposure 46(92%) samples have previous experience, and 04(08%) samples not have any previous experience.

Knowledge OF family members regarding ECT :- that 12% samples have good knowledge regarding Electro convulsive therapy, 76% samples have average knowledge and 08% have poor knowledge of Electro convulsive therapy.

Attitude OF family members regarding ECT: 52% samples have negative attitude towards electro convulsive therapy and 48% samples have positive attitude towards electro convulsive therapy.

FREQUENCY PERCENTAGE DISTRIBUTION OF SAMPLE ACCORDING TO KNOWLEDGE SCORE (GRADE) ON ELECTRO CONVULSIVE THERAPY.

TABLE :

(N=50)

GRADE	KNOWLEDGE RANGE	FREQUENCY (F)	PERCENTAGE (%)
POOR	<50	04	08%
AVERAGE	50-75	40	80%
GOOD	>75	06	12%

Frequency/ percentage distribution of sample or attitude score

TABLE :

Attitude	Range	Frequency	Percentage
Negative	14-42	26	52%
Positive	43-70	24	48%

RECOMMENDATIONS:

- A similar study can be replicated on a large sample.
- A similar study can be conducted including the same group of the family members.
- A study can be conducted by using other strategies.
- Non Experimental method can be use.
- Similar study can be conducted on different hospitals.

CONCLUSION:

The present study assess knowledge of relatives regarding Electro convulsive therapy and results show that 12% samples have good knowledge regarding Electro convulsive therapy, 76% samples have average knowledge and 08% have poor knowledge of Electro convulsive therapy. A study to assess attitude of relatives regarding electro convulsive therapy and result shows that 52% samples have negative attitude towards electro convulsive therapy and 48% samples have positive attitude towards electro convulsive therapy.

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