ISSN : 2583-8474(Online)
Volume - 2: Issue-01
Januray-June - 2024

Estd - 2013

DRIEMS
SCHOOL AND COLLEGE OF NURSING

International Journal of

Advanced Research in Medical, Nursing and Health Sciences

(IJARMNHS)

ISSN: 2583-8474 (Online)

INTERNATIONAL JOURNAL OF ADVANCED RESEARCH IN MEDICAL, NURSING AND HEALTH SCIENCES

IJARMNHS

Volume – 2: **Issue – 01,** **January – June - 2024**

Estd - 2013

DRIEMS SCHOOL AND COLLEGE OF NURSING

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ISSN: 2583-8474 (Online)

International Journal of Advanced Research in Medical, Nursing and Health Sciences

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Tangi, Cuttack – 754022, India
Telefax: (0671 – 2595755
For electronic PDF Files
IJARMNHS Papers are available to download from the website: www.ijarmnhs.in

Printed At: A B Graphics, Jagatpur, Cuttack-754021 (Odisha)
Mob: 9437310185
GSTIN No: 21AJBPB7797D1Z1

International Journal of Advanced Research in Medical, Nursing, and Health Sciences

ISSN: 2583-8474 (Online)

EDITORIAL

Dear Readers

I am delighted to serve as the Editor in chief of the International Journal of Advanced Research in Medical, Nursing and Health Sciences (IJARMNHS). It is deliberate to reflect to the new concept and direction of theoretical and clinical research and report of latest advances in health care field. I will do my best to expand the prestige of the journal.

Our journal may provide an ideal forum for exchange of information of scientific papers, innovations in health care facilities, nursing education and administration. Our journal will serve as a venue to explore future trends and applications and for the transmission of information on both theory and practice.

IJARMNHS will gain wide spread acclaim among professionals. Eight shortlisted articles addressing various issues in the field of nursing sciences have been published. I would like to express my gratitude to the eminent personalities, authors, editors, reviewers and all whom have contributed to the success of 1st issue in 2024.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences

IJARMNHS

ISSN: 2583-8474 (Online)

Volume – 2: Issue – 1

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A QUASI-EXPERIMENTAL STUDY TO ASSESS THE EFFECT OF PLANNED TEACHING PROGRAMME ON KNOWLEDGE REGARDING THE EFFECTS OF TELEVISION ON BEHAVIOUR CHANGES AMONG PARENTS OF CHILDREN IN SELECTED AREAS OF ROBERTSGANJ, U.P.

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Abstract

The primary aim of the study is to assess the effect of planned teaching programme on knowledge regarding the effects of television on behaviour changes among parents of children. The study employed a quasi-experimental with one group pretest and posttest research design. The study was carried out Ramgarh village with 50 samples selected by random sampling techniques. There were total of 50 parents of children were given pretest questionnaire, followed by pretest, teaching programme was given to parents of children for 45 minutes. Posttest was conducted after 15 days with same questionnaire for same parents. The result of the study shows that the posttest mean score 15.14 (SD=2.11) was more than the pretest score 9.16 (SD=3.10) the obtained mean difference between the pretest and posttest 5.88 (SD=1.99) the obtained 't' value is 10.1 & it is significant at the level of 0.05. It was inferred that parents of children knowledge was increased regarding effects of television after planned teaching programme. In association, age and informer of parents was significant with the level of knowledge and selected demographic variables.

Key words: knowledge, effects of television, behaviour changes, children, parents.

Introduction

The preschool age children begin watching television with quantitative approach. They actively search for meaning in the content but are still especially attracted to the vivid production feature such as rapid character movement, rapid changes of scene, and intense or unexpected sights and sounds.

Television can have measure effect on children's health. Children who watch a lot of television are less physically fit. They spend less time in playing outdoor/ indoor like running, jumping and other activities etc. Children are more likely to choose food they see on television commercials and that means their choices are not very healthy.

Children in this study watched television 3-4 hours a day, half of which consisted of viewing adult shows. This amount of time is significantly higher than the guidelines of less than 2 hours of a day suggested by the American Academy of Pediatrics (AAP). Most children now a days watch television as a part of their leisure time. It is found that watching television bring harmful effect to children. They can learn bad words or to be violent. The children can also become addicted and this will prevent him from doing other important activity he should be doing[1]

Television can leads to benefits or bad effects on children. Parents should restrict their children to see only programs which can lead to better improvements with them and time spend on television, hoping that their children become good individuals who benefit their community and the world.[2]

Most behavioural scientists have observed that too much of television viewing by the children would result in the exclusion of other healthy activities. Children also find it very difficult to understand the basic difference between fact and fantasy. The children are very much attached by the television which is known for glamour. Experience reveals that the age and stage of child development makes a big difference. It is also true that repeated experiences can become patterns that began in childhood and extend into adolescence. Television can introduce children to stories, traditions and songs.[3]

Children have become much more interest in cartoons over many years and it has become primary action to some lives, typically children begin watching cartoons on television at an early age of six months and by the age of the puberty.[4]

The children who watches too much cartoons on television are more likely to have a Mental and Psychological Effects. From school age up to their graduation and a child watches television around 18,000 hours. This comparison is an outrage because of the amount of television that is watched by a child will have an effect on their brain, emotions and their sense to feel pain[5]

Television can have two major effects on children's health. First, children who watch a lot of television are less physically fit. They spend less time running; jumping, etc. and doing all the other things that help children develop strong hearts, lungs, and muscles. The second effect is on children's nutrition and their ideas about eating. Children are more likely to choose foods they see on television commercials and that means their choices are not very healthy[6]

The child's development level is a critical factor in determining whether the television and other media will have positive and negative effects. Television viewing frequently limits children's time for vital activities such as playing, reading, learning to talk, spending time with peers and family, storytelling participating in regular exercise and developing other necessary physical, mental and social skills according to several studies.[7]

Today people spend most time watching variety of television programs both domestic and foreign. It is very well said that television is heavy weight of all mass media.

Television has become a forceful activity of society because like the family, school, and peers, it directly provides the child with experiences which shape their attitudes and influence their behaviors by watching more time.[8]

Statement of the problem

A quasi- experimental study to evaluate the effectiveness of planned teaching programme on knowledge regarding the effects of television on children among parents of selected areas of Robertsganj, U.P.

OBJECTIVES:-

- To assess the knowledge regarding the effects of television on children among parents.
- To evaluate the effectiveness of planned teaching programme on knowledge regarding the effects of television on children among parents.
- To find out the association of post-test knowledge regarding the effectiveness of television on children among parents with selected socio demographic variable.

HYPOTHESES:

H_1: There will be a significant difference between the pre-test and post-test knowledge score regarding effects of television on children among parents.

H_2: There will be a significant association between post-test knowledge scores with their socio-demographic variables.

Research Methodology:

Research approach: Quantitative approach was selected.

Research design: Pre-experimental one group pretest and posttest research design was selected.

Research setting: Ramgarh village, Robertganj, Uttar Pradesh.

Sample size

The total sample for present study was 50 parents of children.

Sampling Technique: Simple Random Sampling Technique using lottery method.

Variables

- Independent variable: Planned Teaching Programme.
- Dependent variable: Knowledge level of parents regarding effects of Television on children.
- Socio-demographic variables: age, gender, type of family, family income, education level, no. of children, source of information

Criteria for sample collection

Inclusion criteria

- Parents of children of Ramgarh village
- Parents of children who were willing to participate in the research study.

.**Exclusion criteria**

- Who are not present at the time of data collection.

Description of tool

The research tool was divided into two parts:

Part 1: Socio- Demographic variables It consist of personal information of the subjects that include age, gender, type of family, family income, education level no. of children, source of information.

Part 2: Effect of Television Questionnaire It consist of 20 multiple choice questions which is aim to measures an individual's knowledge regarding effects of television.

Category	Percentage	Score
Excellent	76-100%	16-20
Good	51- 75%	11-15
Average	26-50%	6-10
Poor	0-25%	0-5

Table 1 : Scoring & Interpretation

Criterion measure for level of knowledge

Maximum score=20

Minimum score=0

Data Collection Procedure:

The data collection for the study was carried out on 21/6/2019 to 11/6/2019 of with the selection of parents of Ramgarh village. A formal permission was obtained from the Pradhan of village. Researcher first introduce himself to the parents and explained the purpose of study.

Study procedure was explained to the parents and a written consent was obtained. The tool was distributed to the parents and explained to complete the questionnaire by putting tick (√) for correct answer. They were assured that their response would be kept confidential and used only for research purpose. Their pre-test was taken and followed by pretest, teaching programme was given to parents for 45 minutes. Posttest was conducted after 15 days with same questionnaire for same parents. The data will be analysed by using descriptive and inferential statistics on the basis of objectives of the study.

RESULTS

Table 2- Frequency and percentage distribution of sample characteristics

n=50

S.NO	Sociodemographic variables	Frequency (f)	Percentage (%)
1.	**Age**		
	20-25 years	5	10
	26-30 years	2	4
	31-35 years	11	22
	36-40 years	32	64
2.	**Informer**		
	Mother	44	88
	Father	6	12
3.	**Level of Education**		
	Uneducated	2	4
	5^{th} pass	11	22
	10^{th} pass	19	38
	12^{th} pass ad Above	18	36
4.	**Income**		
	10,000	35	70
	10,000-15,000	8	16
	15,000-20,000	3	6
	>20,000	4	8
5.	**Type of family**		
	Nuclear family	29	58
	Joint family	21	42
6.	**Number ofchildren**		

	1	10	20
	2	29	58
	>2	11	11
7.	**Source of information**		
	Television	42	84
	Family & friends	8	16
	Others	–	–

Table 2 reveals the frequency and percentage distribution of characteristics of the study subjects. It shows that about 2/3rd (64%) of parents were 40 years old. As per informer , 88% of parents were mothers and remaining 12% were father. As per education, about 4% parents were uneducated, 22% parents were 5th pass, 38% parents were 10th pass and 36% parents were 12th pass and graduate. Family income , 70% of the parents had monthly income Rs.10,000 and 16% of the parents having monthly income between Rs. 10,000-15,000 , 6% of the parents having monthly income between Rs. 15,000-20,000 and 8% of the parents having monthly income of >20,000. Type of family, 58% parents were belonged to nuclear family and 42% parents were belonged to joint family. Number of children, 20% parents having 1 child, 29% of parents having 2 children and 22% of parents having < 2 children. Source of information 84% of parents had got information from the television and 16% of parents had got information from the family & friends.

Table 3. Frequency and percentage distribution of pre-test knowledge score

n=50

Pre-test Knowledge score	Frequency (f)	Frequency Percentage (%)
Excellent (16-20)	0	0%
Good (11-15)	17	34%
Average (6-10)	25	50%
Poor (0-5)	8	16%

Table 3 depicts the frequency and percentage distribution of pre-test knowledge score. It shows that 34% parents had good knowledge while 50% parents had average knowledge and only 16% parents had poor knowledge. However parents had knowledge about the effects of television.

Table 4 Frequency and percentage distribution of post-test knowledge score

n=50

Post-test knowledge score	Frequency (f)	Frequency percentage (%)
Excellent (16-20)	16	32%
Good (11-15)	33	66%
Average (6-10)	1	2%
Poor (0-5)	0	0%

Table 4 depicts the frequency and percentage distribution of post-test knowledge score. It shows that more than half of the (66%) parents have good knowledge score, 32% parents having excellent knowledge while 2% parents have average knowledge regarding effects of television.

Comparison of pre-test knowledge score with post-test knowledge score

n =50

Group	n	Mean %	SD	df	t value
Pre-test	50	9.16	3.1	48	10.1*
Post-test	50	15.14	2.11	48	

Maximum Score Level = 20

Minimum Score = 0 *** Significant at p>0.05**

Table 5 Illicit the comparison of pre-test and post-test knowledge regarding effect of television among parents. It revealed that there was significant between pre-test (9.16± 3.1) and post-test (15.14± 2.11) knowledge of parents. Hence research hypothesis (H_1) was accepted and null hypothesis (H_0) was rejected.

Determine the association of post-test knowledge regarding the effects of television on parents among children with selected socio demographic variables.

n=50

Sample characteristics	N	Mean	SD	df	Test values F
AGE					
20-25	5	16.2	0	49	5.41*
26-30	2	14	0		

31-35	11	16.09	9.09		
36-40	32	13.7	0.97		
Informer					
Mother	44	14.7	0.07	49	5.45*
Father	6	13.5	0		
Education					
Uneducated	2	15.5	0	49	1.69^{NS}
5^{th} pass	11	14.1	0.0027		
10^{th} pass	19	13.8	0.12		
$>12^{th}$	18	15.3	0.02		
Income					
10,000	35	14.4	0.013	49	0.08^{NS}
10,000-15,000	8	14.7	0.031		
15,00-20,000	3	15	0		
>20,000	7	14.2	0.02		
Family					
Nuclear	29	14.8	0.16	49	1.12^{NS}
Joint	21	14.0	0.04		
Number of children					
1	10	15.1	0	49	0.98^{NS}
2	29	14.6	0.015		
>2	11	13.9	0.0027		
Source of information					
TV	42		14.5	49	0.17^{NS}
Family and friends	8		14.3		
Others	0		0		

***Significant at p<0.05**

Table 5 shows the association of post-test knowledge regarding effects of television on children among parents. It revealed that parents age and informer is significant and other variables are not significant. As there was significant association between pre-test and post-test knowledge

of parents at p>0.05 level. Thus it was concluded that the planned teaching programme was effective in providing knowledge regarding the effects of television on children among parents.

Discussion

The objective of the study was to assess the knowledge regarding effects of television on children among parents of Ramgarh village.

The analysis of data regarding the knowledge of effect of television among parents revealed that in pre-test, 50% were average knowledge, 34% were good knowledge and 16% were poor knowledge.

The analysis of the data regarding the knowledge of effect of television among parents revealed that in post-test, 32% were excellent knowledge, 66% were good knowledge and 2% were average knowledge.

Comparison of pre-test and post-test knowledge revealed that in pre-test, mean score was 9.16 which increased to 15.14 in post-test and standard error was computed to be 3.1 and 2.11. The effectiveness of planned teaching is assessed by using inferential statistics. A two sample 'T' test was applied to evaluate the effect of planned teaching program on the knowledge regarding effects of television on children among parents.

A study was conducted in northern India to know the T.V viewership pattern among children. This study helps to identify time sent or frequency of television watching by children. A sample of 750 respondents is taken from 5 northern states. The result shows respondent watch 3-4 hours of television.38,6% male children and 43.7% female children watch 3-5 hours of television daily very small percent watch less than 1 hour[9]

To find the association of post-test knowledge regarding the effects of television on children among parents with the selected socio demographic variables such as age, and Informer was significant at the level of 0.05.

Conclusion:

In this study the investigator found that planned teaching programme was effective and study shown that there was a significant differences in pretest and posttest knowledge scores on effects of television on children among mothers.

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A PRE-EXPERIMENTAL STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME ON KNOWELEDGE REGARDING HEALTH HAZARDS OF USING SMART PHONE AMONG COLLEGE STUDENTS AT SELECTED COLLEGES ROBERTSGANJ, U.P

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ABSTARCT

The main aim of the study was to enhance the knowledge regarding health hazards of using smart phone among college students. The quantitative pre-experimental with one group pretest and post research design was used in the present study which includes 60 students of Sai Hospital & Institute of Pharmacy selected by purposive sampling technique. Data was collected from students by using socio-demographic variables and self structured knowledge questionnaire followed by pretest, teaching programme was given to students for 45 minutes. Post test was conducted after after 15 days with same questionnaire for same students. The results of the study showed that the pre-test knowledge scores was 73.4% students had average knowledge, 21.6% students had below average, 3.4% students had good knowledge and 1.6% students had poor knowledge score regarding health hazards of using smart phones. Post-test knowledge scores showed that 51.6% students were average knowledge and 48.4% of students were good knowledge and no students had below average and poor knowledge score. It was inferred that students knowledge was increased regarding health hazards of smart phone after structured teaching programme. In pre-test, mean score was 14.4 (SD=3.06) which increased to 19.71 (SD=2.42) in post-test and standard error is 0.50. The value of 't' is significant at $p<0.05$ level is 10.62.

Key words- knowledge, health hazards, smart phones, college students.

Introduction

Smart phone addiction is the commonest among all adolescent. Adults are facing the health hazards due to excessive smart phone abuse. The emission from a cell phone can be extremely

harmful, causing tumors, memory loss, and increased blood pressure and weakening the immune system.

Smart phone is a small portable communication device that enables people to make phone calls whenever where they are. Signal transmission is very basic concept for smart phone. The convenience of the smart phone is allowing people to communicate with one another without the limitation of region and time. Smart phone is a device providing two way communications. The technology influencing on smart phone back in the mid 20th century the very first smart telephony service was in Sweden[1].

The whole world is gripped by the smart craze, whether it is a student, house wife, shopkeeper, rickshaw driver, and milkman professional, rich or poor almost everyone carries a cell phone in his/ her hand. A smart phone must have item for many average teenagers. Many people spend more than six hours a day on their phones in talking, texting and playing games. The extensive use of cell phone is making us addict of this small device. Just like every medicine has its side effect, cell phone also has its drawbacks. The increased usage of smart phone has increased magnitude of potential health risk among its users[2].

Smart phone radiation disturb sleep pattern because electromagnetic field from smart phone use in bed significantly increase brain activity during early, non rapid eye movement sleep. For people who have used their cell phones for more than ten year and use their phones on the same side the tumor developed. It appears there was an association due to increase of electromagnetic and radio wave radiation, increasing number of illness such as neurodermatitis, fatigue, asthma, heart disease, depression, sleep disorder and ill temper are an the risk[3].

The smart telecommunication has source of radio frequency radiation that produce energy heat up to tissue. During use smart phone usually kept close to the ear which is very near to the brain. It is suspected that continuous use of smart phone for large time may damage brain tissue[4].

Karnataka government has planned to ban the use of smart phone for children up to the age 16 year. The reason for this ban is its adverse health effect, almost 2 year after smart phones were banned in school and colleges (In Karnataka)[5].

Cellular phones increase the risk of brain cancer (brain tumor) and it also cause biological damage through heating effect. It cause other symptoms including headaches, ear ache, blurring of vision, short- term memory loss, and numbness, tingling and burning sensation, bad sleep, fatigue and anxiety. Single and double strand DNA breaks in brain cells increased after exposure

to radio frequency (RF). Exposure to both continuous wave and pulse RF (Smart phones) produced DNA damage. Research by other scientists indicates that prolonged use of smart phones may be lead to Alzheimer's disease or cancer (Brain tumor)[6].

The biological effect of radiofrequency fields, current risk assessment is still limited. Apart from this various studies of smart phone, it over usage leads to smart phone dependence. The smart phone addiction mean that, usage of smart in compulsive repeated manner which the person cannot resist it is one of the biggest non drug addiction in world[7].

STATEMENT OF THEPROBLEM

A pre-experimental study to assess the effectiveness of structured teaching programme on knowledge regarding health hazards of using smart phones among college students at selected colleges of Robertsganj, U.P.

OBJECTIVES OF THE STUDY

- To assess the knowledge regarding health hazards of using smart phones among college students.
- To assess the effectiveness of structured teaching programme on knowledge regarding health hazards of using smart phones among college students.
- To find out the association between post-test knowledge regarding health hazards of using smart phones among college students with selected socio-demographic variables.
- **HYPOTHESES**
- H_1: There will be a significant difference between the pre-test and post-test knowledge score regarding health hazards of using smart phones among college students.
- H_2: There will be a significant association between post- test knowledge scores with selected socio-demographic variables.

RESEARCH METHODOLOGY

- **Research approach :** Quantitative approach was selected.
- **Research design**

  A pre-experimental one group pretest and posttest research design was used

  Pre-Experimental group

$$O_1 \longrightarrow X \longrightarrow O_2$$

  O_1 = Pre-test knowledge regarding health hazards of using smart phones was assessed.

  X = Structured Teaching Programme which was administered to college students.

O_2 = Post-test knowledge regarding health hazards of using smart phones was assessed.

- **Research Setting**
- The present study was conducted in Sai Hospital & Institute of Pharmacy, Robertsganj, U.P
- **Sampling technique:** Purposive sampling technique
- **Variables**
  - **Independent variable:** Structured Teaching Programme
  - **Dependent variable:** Knowledge regarding health hazards of using smart phones.
  - **Extraneous variable:** Age, Gender, Family income, No. of Smart Phones, No. of Sim Card, Duration of Using Smart Phones, Source of Information.

Criteria for sample selection

Inclusion criteria

Students who were-

- Willing to participate in the study.
- Studying in D.Pharm 1st year
- Present at the time of data collection

Exclusion criteria

- Students who were absent on the day of data collection
- Students who were not willing to participating in the study.

DESCRIPTION OF THE TOOL

Tool was divided into two parts:

Part-I Socio demographic variables:

It consist of 7 items i.e. age, gender, family income, no. of sim cards, no. of smart phones, duration of using smart phones, source of information regarding health hazards of using smart phones.

Part-II Questionnaire on knowledge regarding health hazards of using smart phones:

It consists of multiple choice questions to test the knowledge of college students regarding health hazards of using smart phones. The test consist of 26 questions have 4 choice in which one is correct answer. Each correct response carried “1” score and incorrect response carried “0” score. The maximum score is 26 and minimum score is 0 .

Level of knowledge	Score	Percentage(%)
Good	>19	75 - 100%
Average	13-18	50 - 74%
Below average	8-12	25 - 49%
Poor	<7	0 - 24%

Table 1: criterion measure for level for knowledge

Maximum score=26

Minimum score=0

DATA COLLECTION PROCEDURE

The data collection for the study was carried out on 11/10/2019 to 26/10/2019 of with selection of selection studying D.Pharm 1st year at Sai Hospital & Institute of Pharmacy, Robertsganj. A formal permission was obtained from the principal of the college. Researcher first introduced herself to the respondent and explained study purpose and procedure. Consent was obtained from the students and was selected by purposive sampling technique. A pre-experimental research design was used and the tool was distributed to study subject and their pre-test was taken for 15-20 minutes, then structured teaching programme was given for 60 minutes. After 15 days post test was taken from the subjects. Data analysis was done by descriptive and inferential statistics. Descriptive statistics used was frequency, mean percentage and mean and S.D. inferential statistics were calculated by t –test and ANOVA test.

RESULTS

Table 2- Frequency and percentage distribution of sample characteristics

n=60

S.N	Sample characteristics	Frequency (f)	Percentage (%)
1.	**Age (in years)**		
	<20	1	1.6
	20-21	15	25
	22-23	35	58.4
	>23	9	15
2.	**Gender**		
	Male	54	90
	Female	6	10
3.	**Family income (in rupees)**		
	<15000	10	16.6
	15001-20000	16	26.6
	20000-25000	11	18.4
	>25000	23	38.4
4.	**Number of mobile phone**		
	1	52	86.6
	>1	8	13.4
5.	**Number of sim cards**		
	1	36	60
	>1	24	40
6.	**Duration of mobile use(in hours)**		
	<5	53	88.4
	5-10	7	11.6
	>10	0	0
7.	**Source of information**		
	Mass media	25	41.6
	Family & peers	11	18.4
	None of these	24	40

Table 2 depicted that in age 58.4% of them were 22-23 years and 1.6% of them were <20 years. In gender 90% of them were males and 10% were females. The family income states that

38.4% had family income more than 25000 and 16.6% had family income less than 15000. About 86.6% had one smart phone and 13.4% had more than one smart phone. Around 60% had one sim card and 40% had more than one sim card. The 88.4% were using smart phone less than 5 hrs. and no one was using smart phones more than 10 hrs. About 41.6% had information regarding health hazards of using smart phone from mass media and 18.4% had information from family and peers.

Table 3 - Frequency and distribution of pre-test knowledge score

n=60

Pre-test knowledge score	Frequency (f)	Frequency percentage (%)
Good	2	3.4
Average	44	73.4
Below average	13	21.6
Poor	1	1.6

Table 3 depicts the frequency and percentage distribution of pre-test knowledge score. It shows that 73.4% students had average knowledge while 21.6% students had below average and only 3.4% students had good knowledge .However, 1.6% students had poor knowledge score regarding health hazards of using smart phones.

Table4: Frequency and distribution of post-test knowledge score

n = 60

Post-test knowledge score	Frequency(f)	Frequency percentage (%)
Good	29	48.4
Average	31	51.6
Below average	0	0
Poor	0	0

Table 4 depicts the frequency and percentage distribution of post-test knowledge score. It shows that 51.6% had average knowledge score 48.4% had good score. However no students had below average and poor knowledge score regarding health hazards of using smart phones.

Comparison of pre-test and post-test knowledge score.

n=60

Level of knowledge					
Group	**n**	**Mean**	**SD**	**Df**	**'t'**
Pre-test	60	14.4	3.06	59	10.62*
Post-test	60	19.71	2.42	59	

***Significant at p<0.05**

Table 5 depicts the effectiveness of structured teaching programme by comparing pre-test and post-test regarding health hazards of using smart phone. In pre-test, mean score was 14.4 (SD=3.06) which increased to 19.71 (SD=2.42) in post-test and standard error is 0.50. The value of't' is significant at p<0.05 level is 10.62.

Hence, it is concluded that the structured teaching programme was effective in improving knowledge of the students.

Association between post- test and socio-demograhic variables.

n=60

Sample Characteristics	**N**	**Mean**	**SD**	**df**	**Test value 'f'**
Age (in years)					
<20	1	24	0	3,56	2.71^{NS}
20-21	15	18.86	0.25		
22-23	35	20.2	0		
>23	9	18.7	0.23		
Gender					
Male	6	18.83	0.0081	1,58	0.85^{NS}

Female	54	19.81	0.042		
Family income(in rupees)					
<15000	10	18.9	0	3,56	18.7*
15001-20000	16	19.87	0.02		
20001-25000	11	19.27	0.009		
>25000	23	20.17	0.018		
Number of smart phones					
1	52	19.76	0.031	1,58	0.017NS
>1	8	19.37	0.014		

Table 6 depicts that no significant association between post test knowledge regarding health hazards of using smart phones with selected socio demographic variables like age, gender, no. of smart phones, no. of sim cards, duration, source of information. There is only one significant association between post test knowledge regarding health hazards of using smart phones with family income.

DISCUSSION

The objective of the study was to assess the knowledge regarding health hazards of using smart phone among 1st year D.Pharm students of Sai Hospital & Institute of Pharmacy at Robertsganj.

The analysis of data revealed the percentage distribution of pre-test knowledge score. It shows that 73.4% students had average knowledge while 21.6% students had below average and only 3.4% students had good knowledge. However, 1.6% students had poor knowledge score regarding health hazards of using smart phones

The analysis of data revealed the percentage distribution of post-test knowledge score. It shows that 51.6% students had average knowledge score, 48.4% students had good score. However no students had below average and poor knowledge score regarding health hazards of using smart phones.

The analysis of data revealed the effectiveness of structured teaching programme by comparing pre-test and post-test regarding health hazards of using smart phone. In pre-test, mean score was 14.4 (SD=3.06) which increased to 19.71 (SD=2.42) in post-test and standard error is

0.50. There is a significant difference in mean of pre-test scores and post scores. Effectiveness of structured teaching is assessed by using inferential statistics. Paired‘t’ test was applied to evaluate the effectiveness of the structured teaching programme on the knowledge regarding health hazards of using smart phone. The value of ‘t’ is significant at $p<0.05$ level is 10.62.

A descriptive study was conducted on association of smart phone radiation with fatigue, headache, dizziness, tension & sleep disturbance in Saudi population. In this study 437 subjects were taken by convenience sampling technique in which 55% were male and 39% were female. Data were collected by using a questionnaire. The study results showed that people suffered from 21.65% headache, 4.03% sleep disturbance, 3.87% tension, 2.97% fatigue & 2.43% dizziness.So this study concluded that use of smart phones should be avoided by health promotion activities such as group discussion & public presentations.[8]

H_1: There will be a significant difference between the pre-test and post-test knowledge score regarding health hazards of using smart phones among college students.

So, it is concluded that the structured teaching programme was effective in improving knowledge of the students. Hence, H_1 is accepted and H_0 is rejected.

The study revealed that in association, there was significant relationship between family income regarding health hazards of using smart phones. There is no significant relationship between age, gender, no. of smart, no. of sim card, duration of smart use and source of information.

CONCLUSION

In this study the researcher found that structured teaching programme was effective and study shown that there was a significant differences in pretest and posttest knowledge scores on health hazards of smart phone among 1st year D.Pharm students.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences, Volume 2, Issue.1 2583-8474 (Online)

INVESTIGATING THE UNDERSTANDING OF PROTEIN ENERGY MALNUTRITION AMONG MOTHERS OF UNDER-FIVE CHILDREN IN SELECTED RURAL AREAS OF YAMUNA NAGAR.

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Abstract

Background and objective: One of the most significant health issues that is prevalent in the rural areas of Haryana is the lack of protein and energy reserves. The condition is most common in infants and young children who are in their first year of life. **Objective:** This study intends to detect mothers' knowledge on protein energy malnutrition for children under the age of five years in chosen rural areas in Yamuna Nagar City. **Materials and method:** A pre-experimental study was conducted in the pastoral area of Yamunanagar (Haryana), located in North India. Samples were collected using a non-probability purposive sampling technique in this investigation. This sample was composed of thirty mothers who had infants under the age of five. The questionnaire was developed and distributed to mothers of children under the age of five. A panel of experts was used to verify the validity of the questionnaire instrument. A pilot study was conducted to assess the reliability of statistical evaluations. Six mothers were arbitrarily selected (and excluded from the study results). The data was collected using the interview method, and the analysis was conducted using descriptive and inferential statistics. **Results:** The study's main conclusions show that there was a difference in the mean knowledge score of 56.6% and SD of 4.36 % between the pre- and post-tests for cardiac rehabilitation. In contrast to the pre-test mean knowledge score of 33.76% with a standard deviation of 2.34%. The statistical t test indicates that there was a statistically significant 5% level $p<0.01\%$ difference in the knowledge score between the pre- and post-test. Additionally, the enhancement score had a mean of 34.6% and an SD of 15.1%. The statistical significance of the enhancement scores, which indicate the impact of the success of the video assisted programme among the respondents, is revealed by the paired t test result of 8.017. **Conclusions:** There is a notable disparity between the level of knowledge mothers

of children under the age of five have before and after a test, specifically in relation to protein energy deficiency. This demonstrates that the structured training programme was a successful teaching intervention in enhancing the mothers' understanding of protein energy deficiency.

Keywords: Assessment, Mother's knowledge, protein energy malnutrition.

Introduction

Children represent our future hopes.With care, potters can turn wet clay into something lovely, or they crack and are abandoned.The most vulnerable group in society. The most essential part of our population is children, who deserve attention from family, society, and government. Carefully planned education, health, and nutrition policies address their requirements. For optimal physical, mental, and emotional development of future citizens, children are the most crucial component of a nation.[1] Family and nation wealth depend on child health. Good diet is essential for growth and lifelong health. Nutrition involves a dynamic process that uses food for nourishment, structure, and function in every cell of the body. National growth and economic prosperity demand healthy under-5s with adequate diet.[2]

Malnutrition is like an iceberg, affecting most developing country children. Malnutrition can be caused by a lack of a balanced diet, a digestive system disorder that prevents food nutrients from being properly absorbed, or when the body does not get enough vitamins, minerals, and other nutrients to maintain healthy tissues and organ function.[3] Well-nourished women are healthy and can care for their families. Pregnancy and lactation improve with health. Women who are pregnant or breastfeeding have higher nutritional needs. Food helps the mother meet the baby's nutritional demands during pregnancy.Food helps mothers produce breast milk during lactation.[4] About 60% of mortality in developing country children under five are due to malnutrition, according to WHO data. Almost 90% of the 50.6 million under-5 hungry children were from developing countries.[5]

Food and Agriculture Organisation estimates that 925 billion people are malnourished as of October 2010. The estimated proportions of diarrhoea 61%, malaria 57%, pneumonia 56%, and measles 45% mortality due to starvation are similar.[6] Malnutrition causes more than half of all paediatric fatalities in India, but it is rarely identified as the direct cause. More than 6000

children under five die daily from infectious diseases worsened by it.[7] In the 2001 Karnataka census, under-5 mortality was 69/1000 live births. The census also found 6.2% of children with severe undernutrition, 39.0%, and 9.4% normal. These findings show that Karnataka's under-5s are malnourished.[8] Protein needs vary by age, sex, physical, physiological, and other characteristics. ICMR 1981 advised 1.83 mg per kg of body weight of protein for 1-3 years and 1.56 for 4-5 years, or 22 and 29 gm of total need. 2.3 grams per kg for 3 months, 1.8 for 3-9 months, 1.5 for 9-12 months is the daily protein allowance for infants. Children's mental and social growth depends on their mothers. Mother and kid are viewed as one because the mother is the child's first teacher.[9]

Statement of the Problem

A Study To Evaluate The Impact Of A Structured Teaching Programme On The Knowledge Of Mothers Of Under Five Children Regarding Protein Energy Malnutrition In A Selected Rural Area Of Yamuna Nagar.

Objectives

- To evaluate the pre-test and post-test knowledge of mothers of under-five children regarding protein energy malnutrition.
- To assess the effectiveness of a structured teaching programme about protein energy malnutrition.
- To correlate mothers' awareness of their children under the age of five with certain demographic characteristics.

Methods

Research Approach: Quantitative approach

Research Design: Pre-Experimental Design (One Group Pre-Test Post-Test Design)

Settings: Selected rural area, Yamuna Nagar (Haryana) North India
Population: Mothers having children under five years of age in selected rural areas in Yamuna Nagar.

Sampling Technique: Non – Probability (Purposive Sampling Technique)

Sample Size: 30 Mothers

Research Tool: Structured Knowledge Questionnaire on Protein Energy Malnutrition

Validity: Content validity was obtained from five experts in the field of pediatric nursing. The suggested corrections were done.

Reliability: Test-Retest method was used to test the reliability of the questionnaire and the calculated 'r' value was 0.78 which was found to be reliable.

Data Collection Process: The interview method was used to collect data. On day 1, a pre-test was given to see how much the students knew. On day 7, all of the samples were given a structured training programme, and on day 8, a post-test was given to these samples.

Data Analysis: Data analysis was done through descriptive and inferential statistics.

Results and Interpretations

Table – I: Distribution of Samples according to Socio-Demographic Variables

(n = 30)

S. No	Socio-Demographic Variables		Frequency	Percentage
1.	Age (Years)	21-25	15	50 %
		26-30	11	36.6 %
		31-35	04	13.3 %
		35 and above	00	00 %
2.	Family Income (Rupees)	Less than 1000	4	13.33 %
		1001 - 3000	6	20 %
		3001 – 5000	16	53.33 %
		Above 5000	4	13.33 %
3.	Mothers Education	Illiterate	8	26.66%
		Primary	10	33.33%
		Secondary	5	16.66%
		Graduate	7	23.33%
4.	Type of Family	Nuclear	17	56.66%
		Joint	13	43.33 %
		Broken	0	0%
		Extended	0	0%
5.	Mothers Occupation	House wife	20	66.66%
		Labor	4	13.33%
		Petty Business	4	13.33%
		Any other specific	2	6.66%
6.	Family Members	Three	4	13.33%
		Four	10	33.3%

		Five	12	40%
		Six or above	4	13.33%
7.	**Living Area**	Rural	12	40%
		Urban	16	53.3%
		Tribal and backward	1	3.33%
		Slum	1	3.33%

Tha data presented in the tabel 1 reveals that the proportion of mother were in the age group of 15(50%) in the group of 21-25 years, 11(36.6%) in the age group of 26-30 years, 4(13.3%) in the age group of 31-35 years. The data presented in the table one reveals that the proportion of mothers family income were 4 (13.33%) is > than 1000, 6 (20 %) is 1001 – 3000, 16 (53.33%) is 3001 – 5000, 4 (13.33%) is above 5000. The data presented in table 1 reveals that the proportion of the mother education were 8 (26.66%) are illiterate, 10 (33.33%) are primary, 5 (16.66%) are secondary, 7 (23.33%) are graduate. The data presented in the table 1 reveals that the proportion of mothers were in the type of family 17(56.66%) in nuclear family, 13 (43.33%) in joint family. The data Presented in the table 1 reveals that the proportion of mother were in occupation 20 (66.66%) are house wife, 4 (13.33%) are labor, 4 (33.33%) are petty business, 2 (6.66%) are other specific. The data persented in the table 1 reveals that the proportion of mother were family member 4 (13.33%) have three, 10 (33.3%) have four, 12 (40%) have five, 4 (13.33%) have six and above. The data presented in the table 1 reveals that the proportion of the mother were in the living area 12 (40%) in rural, 16 (53.3%) in urban, 1 (3.33%) are in tribal and backward remaining 1 (3.33%) in slum.

Table – II Pre-test and Post-test on knowledge level regarding protein energy malnutrition among mothers of under five children

(N = 30)

Aspect	**Respondent knowledge level**			
	PRE-TEST		**POST-TEST**	
	NUMBER	**PERCENTAGE**	**NUMBER**	**PERCENTAGE**
Inadequate (<50%)	21	70%	3	10%
Moderate (51%- 75%)	4	13.3%	3	10%
Adequate (>75%)	5	16.67%	24	80%

The analysis of the pretest and posttest results indicates a significant improvement in knowledge levels among the respondents. Prior to the intervention, 70% of the respondents had inadequate knowledge, while 13.3% had moderate knowledge and 16.67% had adequate knowledge. Following the intervention, the percentage of respondents with inadequate knowledge decreased to 10%, those with moderate knowledge remained at 10%, and the percentage of respondents with adequate knowledge increased to 80%.

Table – III: Effectiveness of Teaching on Protein Energy Malnutrition Among Mothers of Under Five Children.

N=30

Aspect	Max Score	Respondent knowledge			Paired t - test
		Mean	Mean%	SD	
Pre-test	30	10.76	33.76%	2.34	8.017*
Post-test	30	17.00	56.5%	4.36	

Significant at level.t(8.017,57df)=1.091

The results presented in Table-3 demonstrate the difference in knowledge scores of cardiac rehabilitation between the pre-test and post-test. The post-test mean percentage score of 56.5% (SD=4.36) was significantly higher compared to the pre-test mean score of 33.7% (SD=2.34). The paired t-test yielded a statistically significant difference ($p<0.01$) between the pre-test and post-test knowledge scores, with a calculated t-value of 8.017*. This indicates a statistically significant effectiveness of the video-assisted teaching program.

TABLE 1V: Associations Between the Levels of Knowledge In Post-Test With Selected Demographic Variables.

N=30

Variables	Level of Knowledge			Total	Chi-square	P Value
	Moderate	Inadequate	Adequate			

Family type						
Nuclear	1	0	16	17	5.57	N.S.
Joint	2	3	8	13		
Broken	0	0	0	0		
Extended	0	0	0	0		
Age (in years)						
21-25	2	1	12	15	2.15	N.S.
26-30	1	2	8	11		
30-35	0	0	4	4		
<35	0	0	0	0		
Education						
Illiterate	0	0	8	8	13.23	S
Primary	0	0	7	7		
Medium	3	2	3	8		
High	0	1	6	7		
Occupation						
House Wife	1	3	16	20	26.94	N.S.
Labor	1	0	3	4		
Petty Business	1	0	1	2		
Other Specific	0	0	4	4		
Family members						

Three	0	0	4	4	6.73	N.S.
Four	2	1	7	10		
Five	1	2	9	12		
Six and above	0	0	4	4		
Habitat						
Rural	2	0	10	12	3.87	N.S.
Urban	1	3	11	15		
Tribal and Backward	0	0	2	2		
Slum	0	0	1	1		
Family income						
>3000	0	0	4	4	25.39	S.
1001-3000	0	0	6	6		
3000-5000	2	2	11	15		
5000<	2	0	3	5		

Table IV - Inferred that there are two significant and five nonsignificant association between post-test level of knowledge with demographic variables.

Discussion

The study aimed to assess the effectiveness of teaching about protein energy malnutrition in improving the knowledge of mothers with children under five. The findings indicated that the teaching was effective in increasing knowledge among mothers in rural areas.

In this study, the demographic findings reveal that out of the respondents, 8 (26.6%) mothers are illiterate, 10 (33.3%) have primary education, 5 (16.6%) have middle school education, and the remaining 7 (23.3%) are graduates. As for the age of the patients, 15 (50%) are aged between 21-25 years, while 11 (36.6%) are in the 26-30 age range. In terms of occupation, 20 (66.6%) are housewives, 4 (13.3%) are laborers, 4 (13.3%) are involved in petty business, and 2 (6.66%) have other occupations. Regarding family income, 4 (13.3%) earn less than 1000, 6 (20%) earn between 1001 to 3000, 16 (53.53%) earn between 3001 to 5000, and 4 (13.3%) earn above 5000. For family size, 4 (13.3%) have three members, 10 (33.3%) have four

members, 12 (40%) have five members, and 4 (13.3%) have six or more family members according to the respondents.

The aforementioned findings mirror those of a study conducted by **Prashant V. Pawar and Veerabhadrappa G. Mendagudli (2019).** The study aimed to assess the effectiveness of a planned teaching program on the prevention of protein-energy malnutrition among mothers of children under the age of five. The study involved the analysis of demographic data of mothers in selected rural communities, focusing on the frequency and percentage distribution. The results indicated that the majority (58%) of mothers of children under five years old were in the 21-25 age group, with 30% below 20 years, 12% in the 26-30 age group, and none in the 31 and above age group. In terms of religion, 58% were Muslim, 34% were Hindu, and 8% were Christian. Regarding dietary habits, 52% consumed a mixed diet, 26% consumed non-vegetarian food, and 22% consumed a vegetarian diet. Furthermore, 76% of the mothers came from nuclear families, while 24% were from joint families. In terms of income, 62% had a monthly family income of 1000-3000, 38% had an income of 3001-5000, and none reported an income of 50001 and above. Education-wise, 50% of the mothers had primary education, 34% had education up to higher secondary, 16% had education up to a degree, and none were illiterate. Additionally, 92% of the mothers had one child, while 8% had two children. In terms of immunization, 88% of the children were partially immunized, 12% were completely immunized, and none were not immunized. The study also highlighted that 30% of mothers acquired knowledge from the media, 30% from family members, 28% from newspapers, and 12% from health personnel.

In this study the analysis indicates the overall knowledge score of protein energy malnutrition in the pretest and post-test which reveals that post test mean percentage score was found higher (56.5%) and SD of (4.36%) when compared with the pretest mean knowledge score value which was 33.76 % with SD OF 2.34%. The statistical paired :t: test implies that the difference in pre-test and post-test knowledge scores was found statistically significant 5% level $p< 0.01$. The paired t-test worked out (8.01) revels that there exist a statistical significance of the effectiveness of the teaching program.

J.C, FRANK & Chaudhary, Dr. & Rajwant, Dr. (2022) conducted a study using a pre-experimental one-group pre-test and post-test method. The sample consisted of 40 participants selected using purposive sampling technique. A structured questionnaire was used to assess the participants' knowledge regarding the prevention of protein energy malnutrition. In the pre-test, 34 (85%) participants had inadequate knowledge, 4 (10%) had moderate knowledge, and 2 (5%) had adequate knowledge. Following a structured teaching program, the post-test results showed that 20 (50%) participants had adequate knowledge and 20 (50%) had moderate knowledge.

Conclusion

The study revealed a significant knowledge deficit in all aspects of preventing malnutrition. The findings suggest that the organized teaching program successfully brought about positive changes in the cognitive and behavioral patterns of mothers with children under the age of five in selected areas of Yamuna Nagar, Haryana. The data indicates that the mothers experienced a notable increase in knowledge pertaining to the prevention of malnutrition, demonstrating the effectiveness of the teaching program. The structured teaching program focused on preventing malnutrition proved to be an acceptable and valuable method for educating mothers with young children.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences, Volume 2, Issue.1 2583-8474 (Online)

IMPORTANT SCALES IN PSYCHIATRY FOR NOVICE RESEARCHER

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Introduction

Psychiatry uses standardized methods to objectively assess and sometimes measure psychological phenomena and other clinically relevant areas. This makes it easier to communicate, verify, and analyze these phenomena statistically. **(Moller et al. 1996).** It is crucial to develop models of psychopathology.

In the field of psychiatry, standardized procedures are commonly used in several key areas. These include cross-sectional quantitative description of psychopathological abnormalities, standard assignment of individual cases to diagnostic categories, and quantitative assessment of changes over time in psychopathological abnormalities, with or without therapeutic interventions.

Remember that Standardized measurement procedures can be grouped into standardized assessment tools, systematic behavioural analysis, and objective tests. The term "standardized assessment tool" or "rating scale" refers to structured methods of evaluating current and/or past behaviour and/or experiences. These standardized assessment procedures are especially useful for examining a wide range of psychiatric symptoms and are more practical as they are less restrictive than other procedures. Various interview schedules are available and widely used for this purpose.

Standard rating scales used to measure mental health typically provide data at the ordinal scale level, meaning they give a rank order but not necessarily equal intervals between points on the scale. The conundrum in measurement arises when more detailed and precise measurement instruments come with greater restrictions on what can be measured. This usually results in a more abstract interpretation of the phenomena being measured, which is known as the reliability/validity dilemma.

In adherence to test theory, standardized assessment instruments are expected to adhere to specific quality criteria as outlined by Lienert (1969), Fischer (1974), and Sarris and Rey (1981).

Objectivity	It's crucial that the results remain consistent, regardless of who conducts the assessment and interprets the findings. Standardizing the procedure, analysis, and interpretation is essential to ensure uniform results, regardless of who administers or analyzes the instrument.
Reliability	The consistency of a standardized assessment instrument in recording a characteristic is referred to as reliability. When the measurement is repeated, it should yield the same result.
Validity	The instrument should accurately record what it is meant to measure. The connection between the measurement results and any available external criteria for assessing what should be measured should be as close as possible.
Practicability	The resources needed to administer standardized assessment instruments should be minimized in terms of time, staff, and material.

Here are some commonly used rating scales:

1. **Depression Rating Scales**:
    - Keep in mind that more than two dozen depression rating scales have been developed over the past eighty years.
    - Examples include the **Beck Depression Inventory**, **Hamilton Depression Rating Scale**, and **Patient Health Questionnaire-9 (PHQ-9)**.
2. **Anxiety Rating Scales**:
    - These assess anxiety symptoms and severity.
    - Examples include the **Generalized Anxiety Disorder 7 (GAD-7)**, **Hamilton Anxiety Scale**, and **Beck Anxiety Inventory**.
3. **ADHD Rating Scales**:
    - Used for assessing attention-deficit/hyperactivity disorder (ADHD).
    - Examples include the **ADHD Rating Scale** and **Conners Comprehensive Behavior Rating Scale**.
4. **Autism Spectrum Rating Scales**:
    - Used to evaluate autism spectrum symptoms.
    - Examples include the **Childhood Autism Rating Scale (CARS)** and **Autism Spectrum Quotient (AQ)**.

5. **Dementia and Cognitive Impairment Scales**:
    - Assess cognitive function and mental status.
    - Examples include the **Abbreviated Mental Test Score**

Beck Depression Inventory

The **Beck Depression Inventory (BDI)** is a widely used self-report questionnaire designed to measure the symptoms of depression in individuals. Developed by Dr. Aaron T. Beck, it consists of **21 questions** that assess various aspects of depressive symptoms. Here's a brief overview of the BDI:

1. **Scoring**:
    - Each item is scored on a **4-point continuum** (0=least, 3=most).
    - The total summed score ranges from **0 to 63**.
    - Higher scores indicate **greater depressive severity**.
2. **Key Domains Evaluated**:
    - **Mood**, **pessimism**, **guilt**, **self-dissatisfaction**, and **suicidal thoughts** are among the areas assessed.
    - Subscales include a **cognitive-affective** component and a **somatic-performance** component.
3. **Sample Items**:
    - "I feel sad."
    - "I feel the future is hopeless."
    - "I blame myself for everything bad that happens."

Hamilton Depression Rating Scale

The **Hamilton Depression Rating Scale (HAM-D)**, also known as the **Hamilton Rating Scale for Depression (HRSD)** or simply **HAMD**, is a widely used questionnaire to assess depression symptoms and guide treatment evaluation. Here are the key points about the HAM-D:

1. **Purpose**:
    - The HAM-D is administered by health care professionals.
    - It rates the **severity of depression** in patients.

2. **Structure**:
    - The scale contains **21 items**, but the score is calculated based on the first **17 answers**.
    - It covers various domains related to depression symptoms.
3. **Sample Items**:
    - **Depressed Mood**: Assessing sadness, pessimism, and weeping.
    - **Feelings of Guilt**: Evaluating self-reproach and guilt-related thoughts.
    - **Suicidal Ideation**: Examining suicidal thoughts or gestures.
    - **Insomnia**: Differentiating between initial, middle, and delayed insomnia.
    - **Work and Interests**: Gauging productivity and interest levels.
    - **Retardation**: Detecting slowness, apathy, and stupor.
    - **Agitation**: Measuring restlessness associated with anxiety.
    - **Anxiety (Psychic and Somatic)**: Assessing tension, worry, and physical symptoms.
    - **Hypochondriasis**: Exploring health-related preoccupations.
    - **Weight Loss**: Identifying significant weight changes.
    - **Insight**: Evaluating the patient's understanding of their condition.
4. **Scoring**:
    - Total scores range from **0 to 63**.
    - Interpretation:
        - **0-7**: Normal
        - **8-13**: Mild Depression
        - **14-18**: Moderate Depression
        - **19-22**: Severe Depression
        - **23+**: Very Severe Depression.

The Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 (PHQ-9) is a useful tool for checking for signs of depression. It uses a simple self-report questionnaire to ask about common problems related to depression. This helps doctors figure out if someone might have depression, keep track of their progress, and see how serious it is.

The Generalized Anxiety Disorder 7 (GAD-7)

The Generalized Anxiety Disorder 7 (GAD-7) is a self-administered questionnaire utilized for the purpose of screening and assessing the severity of generalized anxiety disorder (GAD). Comprising seven items, respondents assign ratings based on their experiences within the preceding two weeks. Each item is graded on a scale from 0 (not at all) to 3 (nearly every day). The cumulative score, ranging from 0 to 21, serves as an indicator of the severity of GAD symptoms, with higher scores corresponding to increased levels of anxiety. When employed as a screening instrument, a score of 10 or higher indicates the necessity for further evaluation. The GAD-7 demonstrates good sensitivity and specificity for GAD, and additionally facilitates screening for other prevalent anxiety disorders.

The **Hamilton Anxiety Scale (HAM-A)**

"The Hamilton Anxiety Scale (HAM-A) is a commonly used tool to measure how severe someone's anxiety is. It was created in 1959 and has 14 questions, each asking about different anxiety symptoms. The questions cover both mental and physical symptoms of anxiety. Each question is answered on a scale from 0 to 4, and the total score can range from 0 to 56. Scores are then used to figure out how severe the anxiety is: less than 17 is mild, 18-24 is mild to moderate, and 25-30 is moderate to severe.

The **Beck Anxiety Inventory (BAI)**

The Beck Anxiety Inventory (BAI) is a widely used self-report questionnaire created by Dr. Aaron T. Beck and colleagues. It aims to assess the severity of anxiety symptoms in individuals over the past month. The inventory consists of 21 items where respondents rate each symptom based on their level of bother, ranging from "Not at all" to "Severely." The total score is calculated by summing the scores across all 21 items.

- **Low anxiety**: Total score of 0–21
- **Moderate anxiety**: Total score of 22–35
- **Potentially concerning levels of anxiety**: Total score of 36 and above.

Conclusion

The text discusses the use of rating scales for the classification of mental illnesses, including the pioneering work of T.V. Moore in creating a rating scale for symptoms of schizophrenia. It also mentions the use of sophisticated methods such as factor analysis and cluster analysis in current research. However, it cautions against expecting too much from these techniques due to ongoing controversy and contradictory results.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences, Volume 2, Issue.1 2583-8474 (Online)

ASSESS THE EFFECTIVENESS OF VIDEO ASSISTED TEACHING PROGRAMME ON KNOWLEDGE AND PRACTICE ABOUT FOOT CARE AMONG PATIENTS WITH TYPE 2 DIABETES MELLITUS AT SELECTED HOSPITALS, ODISHA.

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ABSTRACT

Diabetes is one of our most common and challenging health problems in the 21st century. The gravity of the problem is more serious in India and other developing countries when compared to that with developed countries. A study was conducted to assess the Effectiveness of Video Assisted Teaching Programme on knowledge and practice about foot care among patients with type 2 Diabetes Mellitus at selected Hospitals, Odisha. With the objectives to assess the existing knowledge & practice regarding foot care, to assess the effectiveness of Video Assisted teaching programme and to associate the pre-test knowledge & practice on foot care with selected demographic variables. A one group pretest-posttest design was used to conduct the study. Both male and female patients who were diagnosed have Type 2 Diabetes Mellitus and not having any complications during study period were the population. And the samples were selected by using Simple random sampling technique. The result of the study was the knowledge level about foot care management in pretest Twenty (40%) patients had inadequate knowledge, 24 (48%) of them had moderately adequate knowledge and six (12%) of them had adequate knowledge. In posttest 36(72%) patients had adequate knowledge and 14(28%) of them had moderately adequate knowledge. This result inferred that there was improvement in posttest knowledge level. The pretest mean knowledge score was 16.2 with a standard deviation of 4.65 and posttest mean knowledge score was 22.1 with a standard deviation of 2.65. Paired 't' test was applied to compare pre and posttest mean knowledge score. The result indicated that there is a statistically significant increase in posttest knowledge ($P<0.001$). This finding indicated that video assisted teaching programme is effective. With regard to practice 27 (54%) patient's had inadequate practice and 23 (46%) patient's had moderately adequate practice in pretest. In posttest 31 (62%) patient's had adequate practice and 19 (38%) had moderately adequate practice. It shows that there was an improvement in the level of practice in posttest when compared with pretest practice score. The

mean practice score in pretest was 29.44 with a standard deviation of 3.45. In posttest the mean score was 40.32 with a standard deviation of 6.97. the t value of practice is 12.31 which shows effectiveness. The present study concludes that the knowledge & practice about foot care among patients with type 2 Diabetes Mellitus and found that the patients had inadequate knowledge, inadequate practice. The Video Assisted Teaching Programme was found to be effective in improving the knowledge & practice about foot care among patients with type 2 Diabetes Mellitus.

Keywords: Effectiveness, Video Assisted Teaching Programme, knowledge, practice, foot care, Diabetes Mellitus.

Introduction:

Diabetes is one of our most common and challenging health problems in the 21st century. The gravity of the problem is more serious in India and other developing countries when compared to that with developed countries.

Singh had reported that among population diagnosed as having diabetes mellitus, the prevalence of foot ulcers is 4%-10%. The annual population based incidence was 1.0%-4.1% and the lifetime incidence may be as high as 25%. The ulcers frequently become infected causing greater mobility problems and engender considerable financial costs.

Diabetes mellitus is a group of metabolic disorders characterized by elevated level of glucose in the blood resulting from defects in insulin secretion, insulin action or both. Insulin is a hormone produced by the pancreas, controls the level of glucose in the blood by regulating the production and storage of glucose. In the diabetic state, the cells may stop responding to insulin or the pancreas may stop producing insulin entirely. This leads to hyperglycemia, which may result in acute metabolic and hyperglycemic hyperosmolar non ketotic syndrome. Long term effects of hyperglycemia contribute to macro vascular complications like coronary artery disease, cerebrovascular disease and peripheral vascular disease. Chronic micro vascular complications lead to kidney, eye and neuropathic complications.

The American Podiatric Medical Association had reported that a diabetic foot ulcer is an open sore or wound that most commonly occurs on the bottom of the foot in approximately 15% of patients with diabetes among these 6% develop a foot ulcer will be hospitalized due to infection or other ulcer related complications.

Diabetes is the leading cause of non traumatic lower extremity amputations in the United States and approximately 14-24% of patients with diabetes who develop a foot ulcer

have an amputation. Research however had shown that the development of a foot ulcer is preventable.

Statement of the problem

A study to assess the Effectiveness of Video Assisted Teaching Programme on knowledge and practice about foot care among patients with type 2 Diabetes Mellitus attending Diabetic Clinic at selected Hospitals, Odisha.

Objectives

1. To assess the existing knowledge & practice regarding foot care among patient's with type 2 diabetes mellitus.
2. To assess the effectiveness of Video Assisted teaching programme regarding foot care among patient's with type 2 diabetes mellitus.
3. To associate the pre-test knowledge & practice on footcare with selected demographic variables.

Hypotheses

H1: There is significant increased level of knowledge among patients with type 2 Diabetes Mellitus regarding foot care after VATM.

H2: There is significant increased level of practice among patients with type 2 Diabetes Mellitus regarding foot care after VATM.

RESEARCH METHODOLOGY

Research Approach: Quantitative research approach

Research Design

The research design employed for this study was one group pretest-posttest design.

Setting: This study was conducted at different setting in odisha, Diabetic Clinic of SCB Medical College Hospital and Rudra Hospital from Cuttack.

Variables

Independent Variable

The Video assisted Teaching Programme on Foot Care

Dependent Variable

The knowledge & practice about Foot Care.

Population

A population is a well-defined set that has certain specified properties. In this study male and female patients who were diagnosed to have Type 2 Diabetes Mellitus and not having any complications during study period were the population.

Sampling Technique

Simple random sampling technique was used to select the patients for the study; five patients per day were selected.

Description of the tool

It consists of three sections. Section I Demographic variables.

Section II: Knowledge

The structured interview questionnaire was administered by the investigator. The knowledge questions consisted of 25 questions, correct answer was given a score of 1, and wrong answer was given a score of 0. The total score of 25 on knowledge was converted to 100%.

Level of Knowledge	Percentage
Inadequate knowledge	Below 50%
Moderately adequate knowledge	51 – 75%
Adequate knowledge	76% and above

Table 1 Criteria for Knowledge score

Section III: Practice

Check list was used to score practice level. The practice assessment questions consist of 10 items. Correct answer was given a score of 1, and wrong answer was given a score of 0.the total score was 10 on practice and it was converted to 100%.

Level of practice	Percentage
Inadequate practice	Below 50%
Moderately adequate practice	51 – 75%
Adequate practice	76% and above

Table 2 Criteria for practice score

Data collection procedure:

The main study was conducted for a period of four weeks from 30-12-23to 26-01-24. Fifty patients with type 2 Diabetes Mellitus who met the inclusion criteria were selected using simple random sampling technique. Five patients per day were selected. The purpose of the

study was explained to the patients and informed written consent was obtained from each patient. The demographic data and clinical data were collected. Pretest was conducted using structured interview questionnaire & check list to assess the patient's knowledge & practice about foot care. It took 20-30 minutes.

After the protest the patients were gathered and seated comfortably and STP was given on knowledge about foot care management. It took 25-30 minutes, with 10 minutes allotment for discussion. The investigator informed the date and time of the post-testinterview schedule. After two weeks of Video assisted teaching programme post-test was conducted using the same questionnaire.

Results

Table 3 frequency and percentage of demographic variables

n=50

S.NO.	Variables	Frequency	Percentage
1.	Age		
	a. 31- 40 years	6	12%
	b. 41-50 years	11	22%
	c. 51-60 years	21	42%
	d. 61years & above	12	24%
2.	Gender		
	a. Male	28	56%
	b. Female	22	44%
3.	Residence		
	a. Urban	12	24%
	b. Semi urban	12	24%
	c. Rural	26	52%
4.	Religion		
	a. Hindu	42	84%
	b. Muslim	5	10%
	c. Christian	3	6%
5.	Education		
	a. Non literate	8	16%
	b. Primary school	20	40%
	c. middle school	10	20%
	d. higher secondary school	11	22%
	e. Graduate	1	2%

6.	Occupations		
	a. Home maker	18	36%
	b. Labourer	7	14%
	c. Farmer	19	38%
	d. Business	5	10%
	e. Others	1	2%
7.	Family income (in RS)		
	a. <1000	30	60%
	b. 1001-2000	11	22%
	c. 2001-3000	6	12%
	d. >3001	3	6%
8.	Source of Information		
	a. Health personnel	41	82%
	b. Radio / T.V. / Newspaper	7	14%
	c. Friends / Relatives	2	4%
	Duration of illness		
9.	a. less than 2 years	15	30%
	b. 2-5 years	26	52%
	c. 6-10 years	5	10%
	d. above 10 years	4	8%
10.	Family History of D.M		
	a. Yes	16	32%
	b. No	34	68%
	Relationship		
	a. Father	4	8%
	b. Mother	2	4%
	c. Spouse	9	18%
	d. Siblings	1	2%
11	Fasting Blood sugar value		
	a. 70-110 mg/dl	3	6%
	b. 111-140 mg/dl	9	18%
	c.above 140 mg/dl	38	76%
12	Habit of inspecting feet		
	a. yes	7	14%
	b. No	43	86%
	Inspecting Duration		
	a. Daily	6	12%
	c. Monthly	1	2%
13	Daily exercise		
	a. Yes	3	6%
	b. No	47	94%

Table 3 The distribution of demographic variables and clinical variables of patients with Type2 Diabetes Mellitus. Regarding age 21 (42%) belonged to the age group of 51-60 years and 12 (24%) belonged to 61 years and above. Regarding, Gender Twenty eight (56%) were males, and 22(44%) were females. With regard to the domicile Twenty six (52%) are residing in rural area, Twelve (24%) were from semi urban, Twelve (24%) were from urban area.

Out of fifty patients Forty two (84%) were Hindus and five (10%) were Muslims three were (6%) were Christian. Regarding the educational status, Twenty patients 40% had primary education, 12(24%) had above higher secondary education, and 8(16%) patients were non literate. Based on the occupational status 19 (38%) of patients were farmers,18(36%) patients were homemakers,7(14%) patients were laborer, 5(10%) patients were business.

Out of fifty patients Thirty patients (60%) had income less than Rs 1000. Eleven patients(22%) had income between Rs.1001-2000,six(12%) had income betweenRs.2001-3000,three(6%) had income above Rs.3001.Among the sources of information Forty-one (82%) had information about Diabetes Mellitus from health personnel, two (4%) from relatives, seven (14%) from other sources like TV/Radio/Newspaper.

Regarding duration of illness Twenty-six (52%) patient had diabetes mellitus for a period of two to five years and 15 (30%) had less than two years. Among the family history of Diabetes Mellitus Thirty-four (68%) had no family history of diabetes mellitus and 16(32%) had family history of Diabetes Mellitus. Regarding the recent blood sugar level Thirty-eight (76%) of them had fasting blood sugar value more than 140mg/dl, Nine (18%) of them had between 111-140 mg/dl. Among the habit of inspecting feet Forty -three (86%) of them had no habit of inspecting their feet 7 (14%) of them had habit of inspecting feet.

TABLE 4: Distribution of knowledge level about foot care among patients with type 2 Diabetes Mellitus in pretest and posttest n=50

S.No.	Knowledge level	Pretest		Posttest	
		Frequency	Percentage (%)	Frequency	Percentage (%)
1.	Inadequate knowledge	20	40	-	-
2.	Moderately adequate knowledge	24	48	14	28

3	Adequate knowledge	6	12	36	72

Table 4 shows that the knowledge level about foot care management in pretest Twenty (40%) patients had inadequate knowledge, 24 (48%) of them had moderately adequate knowledge and six (12%) of them had adequate knowledge.

In posttest 36(72%) patients had adequate knowledge and 14(28%) of them had moderately adequate knowledge. This result inferred that there was improvement in posttest knowledge level.

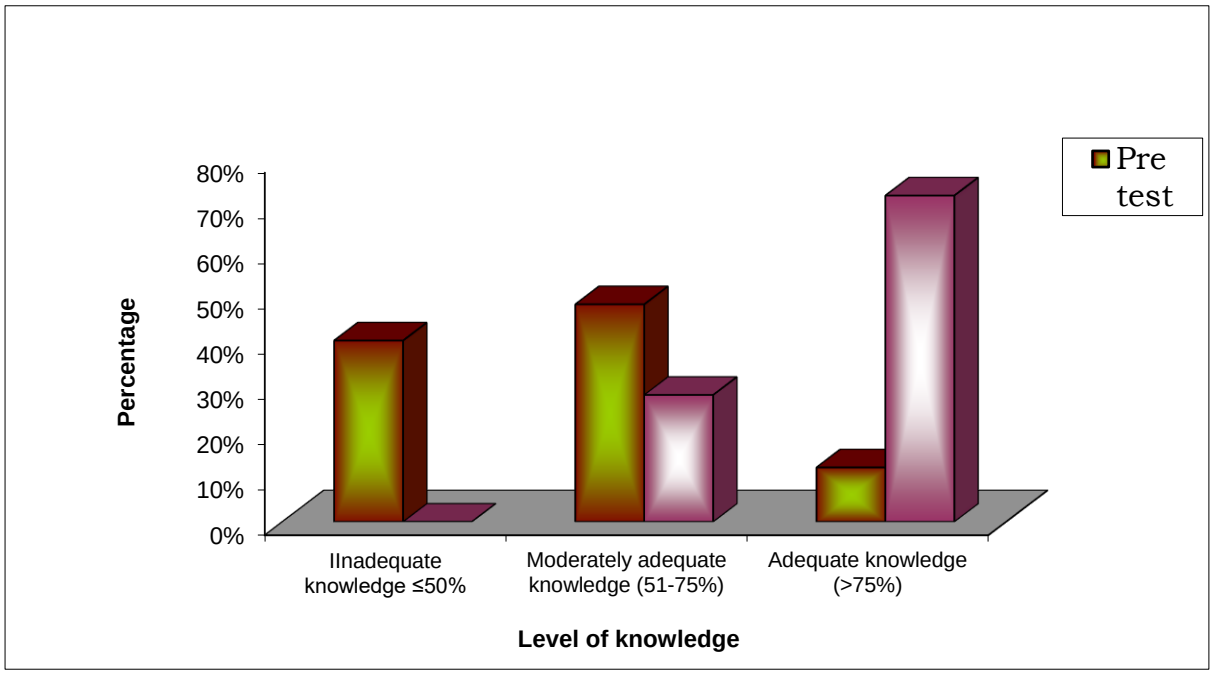

Fig.1. Distribution of level of knowledge about foot care management among patients with type 2 diabetes mellitus in pretest & posttest

Table 5: Comparison of mean and standard deviation of knowledge score of the patients about foot care between pretest and posttest n=50

S.No	Knowledge	Mean	SD	Paired 't' test	'P' value
1.	Pretest	16.2	4.65	12.29	<0.001 (S)
2.	Posttest	22	2.65		

S-significant

Table 5 shows the pretest mean knowledge score was 16.2 with a standard deviation of 4.65 and posttest mean knowledge score was 22.1 with a standard deviation of 2.65. Paired 't' test was applied to compare pre and posttest mean knowledge score.

The result indicated that there is a statistically significant increase in posttest knowledge (P<0.001).This finding indicated that video assisted teaching programme is effective.

Table 6: Frequency distribution of level of practice score on foot care among patient's with type 2 diabetes mellitus in pretest and posttest

n=50

S.No	Level of Practice	Pretest		Posttest	
		Frequency	%	Frequency	%
1.	Inadequate	27	54	-	-
2.	Moderately adequate	23	46	14	28
3.	Adequate	-	-	36	72
	Total	50	100	50	100

Table 6 shows that 27 (54%) patient's had inadequate practice and 23 (46%) patient's had moderately adequate practice in pretest.

In posttest 31 (62%) patient's had adequate practice and 19 (38%) had moderately adequate practice. It shows that there was an improvement in the level of practice in posttest when compared with pretest practice score.

Table 7: Comparison of mean and standard deviation of practice score of the patient's about foot care between pretest and posttest

n=50

Group	Mean	Standard deviation	't' value	'p' value
Pretest	29.44	3.45	12.31	<0.01 (S)
Posttest	40.32	6.97		

S- Significant

Table 7 reveals that the mean practice score in pretest was 29.44 with a standard deviation of 3.45. In posttest the mean score was 40.32 with a standard deviation of 6.97. the t value of practice is 12.31 which shows effectiveness.

The chi square test result indicated that there is no statistically significant association between pretest knowledge with the selected demographic variables.

Discussion

The **first objective** was to assess the existing knowledge and practice level regarding foot care among patients with diabetes mellitus. The study results revealed that out of 50 patients 20(40%) had inadequate knowledge 24(48%) of them had moderately adequate knowledge and six (12%) of them had adequate knowledge.27(54%) patients had inadequate practiceand 23(46%) had moderately practice in pretest.

The **second objective** of the study was to assess the effectiveness of Video Assisted Teaching Programme on knowledge & practice about foot care among patients with type 2 Diabetes Mellitus. Pretest mean knowledge score was 16.2 with a standard deviation of 4.65 and posttest mean knowledge score was 22.1 with a standard deviation of 2.65. Paired 't' test was applied to compare pre and posttest mean knowledge score. The result indicated that there is a statistically significant increase in posttest knowledge ($P < 0.001$). Mean practice score in pretest was 7.36 with a standard deviation of 1.92. In posttest the mean score was 11.44 with a standard deviation of 1.55. The improvement was statistically tested by paired "t" test and the results were found to be significant ($P < 0.01$). It indicated that STP was effective to improve the practice level of the patient's. This finding indicated that Video Assisted Teaching Programme is effective.

The **third objective** of the study was to find the association between pretest knowledge about foot care management among patients with type 2 Diabetes Mellitus with selected demographic variables such as age, gender, domicile, education and occupation and clinical variables such as duration of illness , family history of Diabetes Mellitus and habit of inspecting feet. There are no statistically significant association between pretest knowledge& practice and age, gender, domicile, education, occupation, duration of illness and family history of Diabetes Mellitus.

Conclusion

The present study assessed the knowledge& practice about foot care among patients with type 2 Diabetes Mellitus and found that the patients had inadequate knowledge, inadequate practice. The Video Assisted Teaching Programme was found to be effective in improving the knowledge & practice about foot care among patients with type 2 Diabetes Mellitus.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences, Volume 2, Issue.1 2583-8474 (Online)

INNOVATIVE APPROACHES IN PSYCHIATRIC TREATMENT

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INTRODUCTION

Mental healthcare has undergone a dramatic shift in the last couple of centuries. The last half-decade has shown some of the most exciting innovations in the field of mental healthcare. New treatments and techniques have drastically changed the mental healthcare field.

VIRTUAL REALITY EXPOSURE THERAPY (VRET)

VR is a technology that allows the simulation of different real-life situations in a 3D computer-generated environment in which the user can interact with the environment as if he/she were in the real world.

In VRET, an individual is immersed in a virtual environment, either through the use of a head-mounted display device or entry into a computer-automated room where images are present all around. This environment can be programmed to help the person directly confront feared situations that may not be safe to encounter in real life.

It can help to modify behaviors, thoughts, and emotions which provoke anxiety or fear through virtual experiences. It is used in treating different mental disorders such as specific phobia, post-traumatic stress disorder and social anxiety . Children with ADHD can practice focusing in a VR classroom. People with autism can practice navigating stressful social situations like job interviews.

EYE MOVEMENT DESENSITIZATION REPROCESSING (EMDR)

EMDR was introduced in 1987 as a treatment for post-traumatic stress disorder. It is a psychotherapy treatment that was designed to alleviate the distress associated with traumatic memories.

During EMDR therapy the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist directed lateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used.

EMDR therapy facilitates the accessing of the traumatic memory network, so that information processing is enhanced, with new associations forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in complete information processing, new learning, elimination of emotional distress, and development of cognitive insights.

EMDR therapy is used in treatment of PTSD, Affective disorders, chronic pain, Addiction and Obsessive-compulsive disorders

ARTIFICIAL INTELLIGENCE

Shortages of psychiatrists and therapists worldwide may lead to a rise in AI solutions for mental health

AI algorithms can extract patterns from data, make predictions from these patterns, and continuously update the predictions with the input of new data. This means there is a wide range of potential uses for AI in psychiatry, possibly even including the diagnosis and treatment of people with mental disorders.

Computer-assisted therapy (CAT) could offer exciting prospects in this regard by delivering some aspects of psychotherapy or behavioral treatment. CAT typically consists of programs made up of videos and questionnaires that are delivered to the patient through a computerized platform to help him cope with his symptoms. For instance, Beating the Blues, a computerized-assisted therapy was proven effective in reducing symptoms of depression and anxiety.

CAT could also be delivered via the Internet, thus allowing a higher degree of interactivity between the patient and the program. This approach is referred to as e-therapy. Considering that

Internet is merged into our daily lives, e-therapies could be an effective way to provide support for individuals suffering from mental health disorders.

AI adoption is in its infancy in the mental health fields, but in the future, the AI could aid a clinician in diagnosing a patient, can work in conjunction with designated applications - analyze a host of data like past history, risk factors, side effects, existing treatment guidelines etc.,

TRANSCRANIAL MAGNETIC STIMULATION (TMS)

Transcranial magnetic stimulation is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression, psychosis, anxiety, and other disorders

A typical TMS session lasts 30 to 60 minutes and does not require anesthesia. An electromagnetic coil is held against the forehead near an area of the brain that is thought to be involved in mood regulation.

Then, short electromagnetic pulses are administered through the coil. The magnetic pulses easily pass through the skull, and causes small electrical currents that stimulate nerve cells in the targeted brain region.

CONCLUSION

The future will keep on changing the clinical processes especially with VR, synchronous and asynchronous video conferences and newer technologies that we are yet to utilize may help in reaching the deserved populations.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences, Volume 2, Issue.1 2583-8474 (Online)

Assess the knowledge on oral cancer & its prevention among higher secondary school students of DRIEMS Science College, Tangi, Cuttack, Odisha

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ABSTRACT

A descriptive study with cross sectional survey approach was undertaken to assess the knowledge on oral cancer & its prevention among higher secondary school students at DRIEMS Science College, Tangi, Cuttack. Fifty students were selected by convenient sampling technique & data was collected from the students by using close ended questionnaire. The overall mean percentage scores reveals that the mean score 10.38 ±5.37 which is 47% of the maximum score revealed average knowledge. However, Area wise distribution of mean, SD and mean percentage of higher secondary school students regarding oral cancer & its prevention shows that out of six areas the highest mean percentage (58%) in the area of "prevention" (4.04±1.29) & "introduction" (1.12±0.72) with mean percentage of 56% reveals average area knowledge. However the lowest mean scores obtained were both clinical manifestations (1.32±0.84) which was 33% of mean percentage and signs & symptoms (1.32 ±.95) of mean percentage 40%which shows poor area of knowledge. Further mean percentage score were 50% for "treatment" &, diagnosis 44% were shows again average area of knowledge revealing that they had good knowledge. There is a significant association (P>0.05) between knowledge scores of higher secondary school student with income of parents. But there is no significant association with remaining demographic variable such as age, gender, residential area, occupation of father, occupation of mother, previous source of information & type of family.

Key words: oral cancer, prevention, higher secondary school science students

Introduction

Oral cancer (OC) is a significant worldwide public health problem, with an estimated 377,713 new cases and 177,757 associated deaths in 2020, most common type of OC accounting for over 90% cases. The etiopathogenesis of OC is quite complex, and multiple factors - either individually or synergistically - are involved. Indeed, around 85% of OC cases are preventable as they are attributed to modifiable risk factors including smoking, smokeless tobacco, betel nut, and alcohol, and sun exposure in context of lip and skin cancer.[1]

According to the 2016–2017 Global Adult Tobacco Survey (GATS-2), the prevalence of adult smokeless tobacco (SLT) use in India is 21.4% (29.6% in men and 12.8% in women). Due to its cultural acceptability across genders and high prevalence of use, SLT is a predominant risk factor for OPMDs in India, smokeless tobacco (SLT) is a predominant form of tobacco used among people living with HIV (PLHIV). Despite SLT being a risk factor for oral potentially malignant disorders of those enrolled, 61% were men, median age was 36 years, and 33% currently use SLT. PLHIV that are current SLT users are at high risk of OPMDs and potentially oral cancer.[2]

In 2008, two-thirds of all deaths globally were caused by chronic noncommunicable diseases, mainly cardiovascular diseases (48%) and cancer (21%). Later, in 2016, noncommunicable diseases were responsible for 71% of the 57 million deaths that occurred worldwide, including mainly cardiovascular diseases (44%), cancers (9%), chronic respiratory diseases (9%), and diabetes (4%) [1]. Nevertheless, the evidence shows that cancer mortality decreased by 12% between 2008 and 2016. However, a recurrent observation is the displacement of cancers related to infectious diseases and poverty by cancers linked to lifestyle.[3]

The prevalence rate of the three major risk factors of HNC among secondary school-going adolescents had been rising over the years. The studies show that at least one out of every ten Nigerian secondary school students engage in tobacco smoking, unprotected oral sex, and/or alcohol drinking habits, thereby increasing their risk of developing HNC, Despite the rising prevalence of HNC risk factors among secondary school students, there exists a very low awareness of HNC among them.[4]

A survey in 2012, 15.8% of Sri Lankans which includes 8.6% of the youth were found to be smokeless tobacco (SLT) users, Committee of the National Authority of Tobacco and Alcohol (NATA), issued a gazette notification banning the production, distribution and sale of SLT products in the year 2016. Further, according to the 2018 WHO factsheet on Sri Lanka, tobacco is responsible for 12,351 deaths and it represents 10% of all deaths. It has estimated that there are 2.1 million current tobacco users in the country.[5]

The Global Adult Tobacco Survey (GATS) in India has estimated that 99.5 million (10.7%) of adults currently smoke Tobacco and 199.4 million (21.4%) of adults use the smokeless form of Tobacco. It is also predicted that there are more than 300 million users of smokeless Tobacco globally . As the name indicates, smokeless Tobacco products (STPs) are consumed without smoking (heating), and some consumers use it as an alternative to smoking cigarettes as there is a misconception that STPs are less harmful, even though there is substantial evidence to support carcinogenicity of STPs. According to the "International Agency for Research on Cancer" (IARC), which assesses the carcinogenic risk.[6]

The potential role of high-risk HPV types, particularly HPV-16 as risk factors for the development of oral cancer has been elucidated for decades. Additionally, the burden of HPV-related oral cancer is increasing worldwide. Various studies from developed countries (e.g. North America, Europe, Japan and Australia) reported that 17–56% of all oral cancers are HPV-related.[7]

Based on GLOBOCAN estimates.2012, about 14.1 million new cancer cases & 8.2 million deaths occurred in 2012 worldwide. Over the year the burden has shifted to less development countries, which currently account for about 57% of all cases & 65% of cancer death worldwide.[8]

Cancer of the oral cavity is one of the most common malignancies,1 especially in developing countries but also in the developed world. Worldwide, 405,000 new cases of oral cancer are anticipated each year, the countries with the highest rates being Sri Lanka, India, Pakistan, Bangladesh, Hungary, and France, causing 8,650 deaths. Alcohol and tobacco seem to have a synergistic effect in the etiology of oral and oropharyngeal SCC. However, alcohol is linked to an increased risk of cancer even in nonsmokers. Other factors such as poor oral hygiene, wood dust exposure, dietary deficiencies, and consumption of red meat and salted meat18,19 have been reported as etiologic factors. Pathologically constitute more than 90% of all oral cancers. Other malignant tumors can arise from the epithelium, connective tissue, minor salivary glands, lymphoid tissue, and melanocytes, or metastasis from a distant tumor.[9]

STATEMENT OF PROBLEM

"A study to assess the knowledge on oral cancer & its prevention among higher secondary school students of DRIEMS Science College ,Tangi, Cuttack , Odisha"

OBJECTIVES OF THE STUDY

- To assess the knowledge of higher secondary school students on oral cancer & its prevention.
- To find out the association between knowledge scores with selected demographic variables

Research Methodology

Research approach: The approach for conducting this study was quantitative research approach.

Research design: Research design for this study was non experimental descriptive research design.

Population: The population of the study is higher secondary school science students who meet inclusion and exclusion criteria.

Setting of the study

The present study was conducted in DRIEMS higher secondary school, Tangi, Cuttack.

Sample Size: The total sample for present study was 50 students.

Sampling technique: convenient sampling technique

Ethical Consideration

For the present study the investigators took into consideration of the ethical issues. The research committee accepted the study. Prior permission was obtained from Principal office, DRIEMS Science College, Tangi, Cuttack.

- Explanation regarding purpose of study was given to Head of the institute.
- Anonymity of the participants was ensured.
- Confidentiality of the data was maintained

Data Collection Procedure

The data was collected from higher secondary school students regarding their knowledge on oral cancer and its prevention in their class room after getting permission from Principal, DRIEMS science College, Tangi, Cuttack. Questionnaire was given to higher secondary school students and were explained about the nature and purpose of the study and their expected participation in the study. Samples of 50 higher secondary school students were selected by convenient sampling (was assured and code no was given to each student) and the data was gathered and analysis was done by descriptive and inferential statistics with the help of SPSS 2.0 statistics package.

RESULTS

Tab.1 Distribution of demographic characteristics according to their age, gender, residence, family type, income and religion

n=50

Age (in yrs.)	Number	Percentage (%)
15-17	46	92
18-20	04	08
Gender		
Male	37	74
Female	13	26

Residence		
Rural	35	70
Urban	15	30
Family type		
Joint	34	68
Nuclear	16	32
Income		
<5000	4	8
50001-10000	16	32
10001-20000	23	46
>20000	7	14
Religion	**Number**	**Percentage (%)**
Hindu	47	94
Muslim	03	6

The above table shows that the highest percentage (92%) of +2 students were in the age group of 15-17years, whereas only (8%) were in the age group of 18-20 years. Maximum number of (74%) +2 students was males and only 26% of females were participated in this study, might be because of availability of more male candidates. Majority 70% +2 students were rural and only 30% were living in urban area, 68% belongs to joint family but 32 % are nuclear family, mostly 46% belongs to income of 10001-20000 INR whereas less than 5000 INR is only 8% more over only 14% have more than 20000 INR. Only 36% are earning 5001-1000 INR, 94% were belongs to Hindu religion and only 6% were Muslim.

Table:2. Distribution of demographic according to their no. of children, Father and Mother occupation and sources of information.

n=50

No. of children	Number	Percentage (%)
1	16	32
1-2	18	36
3 and more	16	16
Father Occupation		
Labourer	7	14
Business	21	42
Govt. Employee	14	28
Self-employee	8	16
Mother Occupation		
House wife	49	98
Service	1	2
Sources of information		
Books	20	40
Internet	16	32
Any AV aids	7	14
others	7	14

Participant's family shows that 36% of them are two children in their family but one child family constitutes 32%. Whereas more than three children are accounts the same as 32%, The occupation of father shows that around 42% are indulged in business where as 28% are Govt employees. Only negligible number of 14% belongs to laborer, Mother's occupation shows that 98% includes housewives but only 2% are doing service, Previous source of information says that nearly 48% of the students are using book rather than internet which includes 32%.

Tab 3: Area wise distribution of mean, SD & mean percentage of higher secondary school students on oral cancer & its prevention.

n=50

Area	Maximum score	Mean	SD	Mean (%)
Meaning & definition	2	1.12	0.72	56
Cause & Risk Factor	4	1.32	0.84	33
Sign & Symptom	4	1.58	0.95	40
Diagnosis	3	1.32	0.90	44
Treatment	2	1	0.67	50
Prevention	7	4.04	1.29	58
Over all	**22**	**10.38**	**5.37**	**47**

Table one shows that area wise distribution of mean, SD and mean percentage of higher secondary school students regarding oral cancer & its prevention shows that out of six areas the highest mean percentage (58%) in the area of "prevention" (4.04±1.29) & "introduction" (1.12±0.72) with mean percentage of 56% reveals average area knowledge. However lowest mean scores obtained were both clinical manifestations (1.32±0.84) which was 33% of mean percentage and signs & symptoms (1.32 ±.95) of mean percentage 40%which shows poor area of knowledge. Further mean percentage score were 50% for "treatment" &, diagnosis 44% were shows again average area of knowledge revealing that they had good knowledge.

Tab.4: Association between the knowledge scores of higher secondary school students with their elected demographic variables.

n=50

Sl. No.	Demographic variables	χ^2value	P value	Level of Significance
1	Age	2.6	0.12	NS
2	Gender	0.40	0.81	NS
3	Residential Area	2.9	0.2	NS
4	Type of family	0.17	0.9	NS
5	Income of parents	10.34	0.3	**S**
6	Religion	0.60	0.73	NS
7	Number of sibling	3.23	0.51	NS
8	Father's occupation	4.54	0.60	NS
9	Mother's occupation	0.43	0.80	NS
10	Previous source of information	6.94	0.34	NS
11	In family anybody is known case of cancer	2.44	0.2	NS

For P>0.05=not significant

S-Significant **NS-Not Significant**

The above table reveals that there is a significant relationship between the level of knowledge with income of the parents and remaining demographic variable does not have any significant relationship with knowledge such as age, sex, occupation, type of family, father's occupation, mother's occupation, religion and previous source of information.

Discussion:

The fifty higher secondary school students were given self administered questionnaire on oral cancer and its prevention which contains 6 areas and 22 items. Each

question was having four response options in which one was correct and three were wrong answers.

There were 70% of higher secondary school students having average knowledge on oral cancer and its prevention but 10% of students having poor knowledge and reaming only 10% having good knowledge.

This finding of the study is supported with similar study conducted on knowledge level among dental students regarding oral cancer. In this study they have above average knowledge for 75% of subjects and only 15% have poor knowledge.

Area wise distribution of mean, SD and mean percentage of higher secondary school students regarding oral cancer & its prevention shows that out of six areas the highest mean percentage (58%) in the area of "prevention" (4.04±1.29) & "introduction" (1.12±0.72) with mean percentage of 56% reveals average area knowledge. However lowest mean scores obtained were both clinical manifestations (1.32±0.84) which was 33% of mean percentage and signs & symptoms (1.32 ±.95) of mean percentage 40%which shows poor area of knowledge. Further mean percentage score were 50% for "treatment" &, diagnosis 44% were shows again average area of knowledge revealing that they had good knowledge and it reveals that there is a significant relationship between the level of knowledge with income of the parents.

The association between knowledge scores and socio demographic variables was done using chi square formula. There was significant relationship between knowledge scores and income of the parents. However, there were no significant with other socio demographic variables such as age, gender, religion, previous sources of information, father's occupation, mother's occupation and type of family

Conclusion:

The findings of the present study suggest that the level of knowledge of higher secondary school students on oral cancer and its prevention. Area wise distribution of mean, SD and mean percentage of higher secondary school students regarding oral cancer & its prevention shows that out of six areas the highest mean percentage (58%) in the area of "prevention" (4.04±1.29) & "introduction" (1.12±0.72) with mean percentage of 56% reveals average area knowledge. However lowest mean scores obtained were both clinical manifestations (1.32±0.84) which was 33% of mean percentage and signs & symptoms (1.32 ±.95) of mean percentage 40%which shows poor area of knowledge. Further mean percentage score were 50% for "treatment" &, diagnosis 44% were shows again average area of knowledge revealing that they had good knowledge and it reveals that there is a significant relationship between the level of knowledge with income of the parents and remaining demographic variable does not have any significant relationship with knowledge such as age, sex, occupation, type of family, father's occupation, mother's occupation, religion and previous source of information. This study gives a rough idea about their knowledge because oral cancer is a serious issue in India.

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International Journal of Advanced Research in Medical, Nursing and Health Sciences, Volume 2, Issue.1 2583-8474 (Online)

"EFFECTIVENESS OF PROGRAMMED TEACHING ON LEVELS OF KNOWLEDGE AND EXPRESSED PRACTICES REGARDING FIRST AID MANAGEMENT AMONG PRIMARY SCHOOL TEACHERS PURI ODISHA"

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Abstract

Knowledge of first aid, which involves life-saving treatment for injuries or unexpected illnesses, is crucial for everyone, especially children. Therefore, it is essential for school teachers to have a good grasp of first aid in order to take preventive measures. Objectives: The aim is to assess the level of first aid knowledge among primary school teachers. Methodology: The study utilized a quantitative approach and employed a pre-experimental one-group pre- and post-test design. A non-probability convenient sampling technique was used to select 60 primary school teachers in Puri. There was a mean difference of 15.4 between the mean pre-test knowledge scores (12.3 with SD 2.80) and the mean post-test knowledge scores (27.7 with SD 2.10). The significant difference was determined using a paired t-test. The calculated t value, 36.11, was higher than the table value of 3.66 (at $P<0.05$). An association was observed between pre-test knowledge scores and variables such as the age of the sample and the information source used to acquire knowledge about first aid management ($p<0.05$). In conclusion, it is crucial for all stakeholders to be equipped to manage common emergencies during epidemics or emergency situations in order to maintain a healthy environment.

Keywords: Effectiveness, Programmed teaching, Knowledge, Expressed practice first aid, Management Primary School Teachers

School should be a safe place for all students to learn and play and it is job of eachteacher and administrator to ensure that safety.

Mrs.Susan Teacher & Psychologist

Introduction:

Children are unique individuals and should not be viewed as miniature adults. The childhood period is crucial for socialization, as children learn attitudes, customs, and behaviors from their families and communities. The health status of children in a country is indicative of the country's overall development, as children are major consumers of healthcare. In India, 35%-40% of the total population is children below 15 years of age, and they are considered a special risk group due to their vulnerability to various health problems. Children require special care in order to thrive. Furthermore, childhood injuries are an increasing global public health concern, leading to thousands of deaths and millions of non-fatal injuries each year.

PROBLEM STATEMENT

Effectiveness Of Programmed Teaching On Levels Of Knowledge And Expressed Practices Regarding First Aid Management Among Primary School Teachers At Selected Schools, Puri.

Objectives:

1. To assess the pre-test levels of knowledge and expressed practices regarding first aid management among primary school teachers.
2. To assess the effectiveness of programmed teaching levels of knowledge and expressed practices regarding first aid management among primary school teachers.
3. To find out the association between post-test levels of knowledge and expressed practices regarding first aid management among primary school teachers and selected demographic variables.

Material And Methods

Research Approach - The research approach used for this study was a quantitative approach. The research design used in this study was Pre pre-experimental one-group pre and post-test design. The study was conducted in selected primary schools at Puri. The setting was chosen the basis of feasibility and availability of adequate samples.

POPULATION The target population for the present study was primary school teachers at Puri

SAMPLE The study sample comprises selected primary school teachers government primary school, Puri.

SAMPLING TECHNIQUE; Non probability convenient sampling technique was used for selection samples

SAMPLE SIZE 60 primary school teachers were selected

Result

Aim of the study was to identify the effectiveness of structured teaching program (STP) in improvement of knowledge of primary school teachers on first aid management so that they can extensively use it at school premises to save children at any untoward circumstances.

SECTION _A

Table – I: Frequency and percentage distribution of pre and post-test levels of knowledge regarding first aid management

N=60

KNOWLEDGE	PRETEST		POSTTEST	
Inadequate knowledge	**NO**	**%**	**NO**	**%**
	44	73%	0	-
Moderate knowledge	16	27%	3	5%
Adequate knowledge	0	0	57	95%

Please take note of the following information from Table I, which presents the frequency and percentage distribution of pre- and post-test levels of knowledge regarding first aid management. In the pre-test, inadequate knowledge was present among 44 (73%) of the samples, while moderate knowledge was seen among 16 (27%) of the samples. Adequate knowledge was not present among any of the samples. In the post-test, the majority of the samples, 57 (95%), demonstrated adequate knowledge, while moderate knowledge was present among 3 (5%) of the samples.

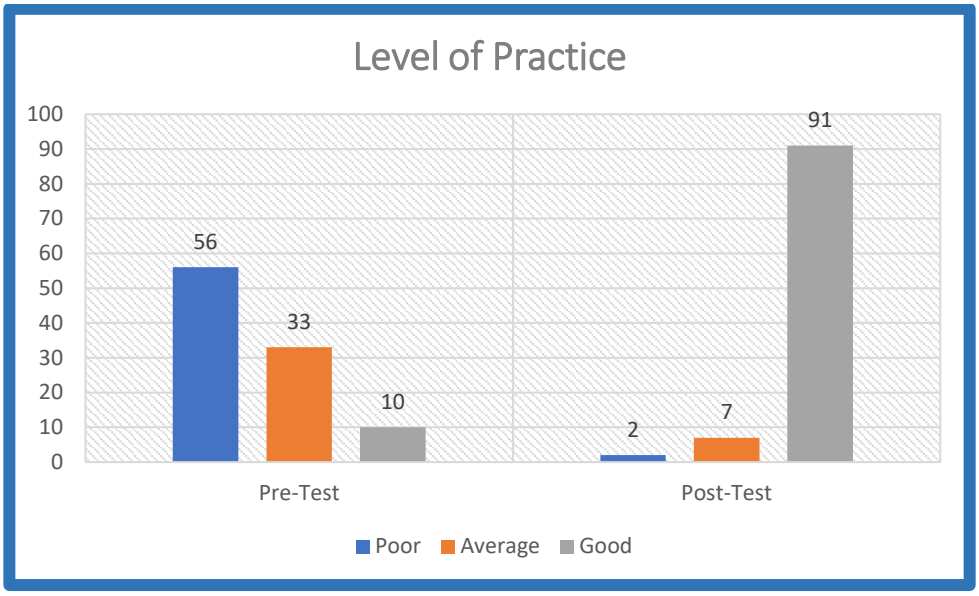

Figure – I: shows the frequency and percentage distribution of pre and post-test levels of expressed practice regarding first aid management

In the pretest, the majority of teachers (53%) had poor expressed practice, while 33% had average and 10% had good expressed practices. After the training in the post-test, a significant improvement was observed, with 73% of teachers demonstrating good expressed practices and 27% showing moderately expressed practices regarding first aid management.

Table – II: Effectiveness of the Structured Teaching Programme

(n = 60)

Level of knowledge	Mean	Standard Deviation	Mean difference	Paired 't' test
Pre-test	12.3	2.80	15.4	36.11*
Post-test	27.7	3.15		

Table – II represents that the pretest knowledge mean score was 12.3, standard deviation 2.80 and the post test knowledge mean score was 27.7, standard deviation 2.10. The mean difference of pre and post test knowledge was 15.4. As the calculated paired t test value is 36.11 was higher than the tablevalue 3.66 ($p<0.05$). Hence there was significant improvement in knowledge regarding first aid management. Therefore hypothesis 1 is accepted.

CONCLUSION:

There was a mean difference (15.4) between mean pre test knowledge scores (12.3 with SD 2.80) and mean post test knowledge scores (27.7 with SD 2.10). Significant difference was calculated using paired t test. Obtained t value is 36.11 which was higher than the table value of 3.66 (at $P<0.05$). There was an association found between pre test knowledge scores and variablessuch as age of sample and source of information used to get knowledge on first aid management ($p<0.05$). in conclusion it is important that every stakeholders must be aware of handling common emergencies during any epidemic or in any emergency situations to keep health environment around us

Pre experimental one group pre & post test design was used with 60 sample. There was a mean difference (15.4) between mean pre test knowledge scores (12.3 with SD 2.80) and mean post test knowledge scores (27.7 with SD 2.10). Significant difference was calculated using paired t test. Obtained t value is 36.11 which was higher than the table value of 3.66 (at $P<0.05$). There was an association found between pre test knowledge scores and variablessuch as age of sample and source of information used to get knowledge on first aid management ($p<0.05$). in conclusion it is important that every stakeholders must be aware of handling common emergencies during any epidemic or in any emergency situations to keep health environment around us.

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