As, the systemic diseases are claiming more prevalence for many reasons like lifestyle, pollutions and changes in environment.

WHO has requested all the countries to include native medicines in the health care system.

We, Indians have deep rooted health care system which included Ayurveda, Siddha, from vedic period onwards. During Moghul period Unani replaced ours, after that the Allopathy system is existing.

Now the Nursing Professionals are Prepared by the bases of Allopathy system only. As slowly the health care delivery system is changing towards our national vedas like Yoga, Naturopathy, Ayurveda and Siddha medicines to retrieve our hereditary life style and economically healthy life.

It has belived that the dangerous diseases like cancer, diabetes mellitus, hypertension, cardio vascular diseases, cerebral problems can be prevented by Yoga and Ayurveda.

Our prime minister is also developing yoga as a method of life activity. So, it is the time for nurses also to think about preparing the nurses to treat the patients / clients according to the needs of the AYUSH treatment modalities.

It is better to have special programs like GNM / B.Sc(N) in yoga and Naturopathy or GNM / B.Sc(N) in Unani etc to provide hospital care to the humanitiy as holistic.

The course outline / syllabus may in the prepared on the treatment modalities of AYUSH to cope with the changing trends in health care.

*Indira. S, Ph.D., Nursing Principal*
1. Retinopathy of prematurity - Dr. Indira. S
2. Impact of intervention on signs, symptoms and management of Pre menopause and menopause women. - Mrs. P. Vara Lakshmi
3. Care protocol for management of various poisonning - Mrs. Subadra Harikrishnan
4. Bioterrorism - Mr. Ramesh. S
5. A study to assess the effectiveness of structured teaching programme on cervical cancer among the women at Venkatachalam, Nellore. - Mrs. N. Bayamma
7. A study to assess the effectiveness of structured teaching programme on prevention of selected puerperal infections among antenatal mothers attending MCH centre at Tirupati. - Ms. Supraja. K
8. A study to assess the knowledge of mothers regarding care of low birth weight babies in Narayana Medical College Hospital, Nellore - Ms. Ramya. K
10. A study to assess the knowledge about growth and development of toddlers among mothers of toddlers in selected rural area of Nellore - Ms. Ruth Grace. M
11. Comparative study to assess the knowledge of mothers on Low Birth Weight Babies between primi and multi grvida attending OPD in Government Maternity Hospital, Tirupati. - Ms. Padma
12. Article on beti bachao-beti padhao - Ms. Sarada. K
**Introduction:**

Retinopathy of prematurity (ROP) or Terry syndrome, previously known as Retro Lental Fibroplasias (RLF), is a disease of the eye affecting prematurely-born babies generally having received intensive neonatal care, in which oxygen therapy is used due to the premature development of their lungs.

It is thought to be caused by disorganized growth of retinal blood vessels which may result in scarring and retinal detachment. ROP can be mild and may resolve spontaneously, but it may lead to blindness in serious cases. As such, all preterm babies are at risk for ROP, and very low birth weight is an additional risk factor. Both oxygen toxicity and relative hypoxia can contribute to the development of ROP.

ROP is a multifactorial vasoprolifeative retinal disorder that increases in incidence with decreasing gestational age.

**Definition:**

Retinopathy of prematurity (ROP) is abnormal blood vessel development in the retina of the eye. It occurs in infants that are born premature.

**Risk factors:**
- Pre maturity - Multiple transfusions
- Low birth weight - Hypo / Hypercarbia
- Shock / Acidosis - Sepsis – Fungal / Bacterial
- Oxygen exposure - Hyperoxia / Hypoxia ventilation

**Screening:**
- Gestation < 34 weeks and / or < 2000 gm at birth.
- Preterm neonates with stormy neonatal course irrespective of gestation and birth weight.
- Any baby with O₂ requirement for 30 days.

When to screen?
- First ROP screening should be done at 3-4 weeks, of post-natal age.
- Repeat examinations should be done based on the stage of ROP till complete regression.

**How to get the babies screened for ROP?**

It is done by the ophthalmologist done bedside by indirect ophthalmoscopy after papillary dilatation.

**How to dilate the pupils for examination?**

Apply drosyn drops (pheny ephrine) comes as 10% solution.
- Add 3 drops of normal saline to 1 drop of drosyn.
- Apply one drop of each of drosyn (2.5%) and Cyclomid (cyclopentolate) 1% to each eye and wipe away the excess drug with cotton.
- Repeat the same every 20 min for 3 times.

**Occurrence of ROP and subsequent events**

**CLASSIFICATION:**

(The ICROP revisited : Arch Ophthlmol’05)

The classification of ROP is based on
- Location
- Extent
- Stage and plus disease.

1. **Location:** The retina is divided into 3 zones
   - **Zone – 1:** Innermost zone, the radius of which is twice the distance from the centre of topic disc to macula.
   - **Zone – 2:** Extends from zone 1 to ora serrata of nasal side and about half of the distance from ora serrata on temporal side.
Zone - 3: Residual crescent of retina on temporal side.
Stage: It is divided into 5 stages.
Stage - 1: Demarcation line that separates a vascular retina interiorly from the vascular retina posteriorly.
Stage - 2: Ridge of scare tissue on the line of demarcation.
Stage - 3: Ridge with extra retinal fibro vascular proliferation or revascularization. Abnormal blood vessels extend into vitreous.
Stage – 4: Partial retinal detachment
  ❖ 4A – detachment – outside the fovea.
  ❖ 4B – detachment – outside the fovea.
Stage - 5: Total retinal detachment.

Stage 2 ROP showing a ridge (R)  
Stage 3 ROP showing extraretinal fibrovascular  
Stage 4: ROP with subtotal retinal detachment

Pre – plus disease:
Intermediate level of vascular dilatation and tortuosity between normal appearing posterior pole vasculature and frank plus disease.
AP-ROP (Aggressive posterior ROP):
This is uncommon, rapidly progressively and sever form of ROP. The characteristics features are its posterior location, prominence of plus disease, its ill defined nature and rapid progression to stage.

Symptoms: There are five stages of ROP.
❖ Stage I: There is mildly abnormal blood vessel growth.
❖ Stage II: Blood vessel growth is moderately abnormal.
❖ Stage III: Blood vessel growth is severely abnormal.
❖ Stage IV: Blood vessel growth is severely abnormal and there is a partially detached retina.
❖ Stage V: There is a total retinal detachment.

Symptoms of severe ROP include:
❖ Abnormal eye movements
❖ Crossed eyes
❖ Severe nearsightedness
❖ White - looking pupils (leukocoria)

Exams and tests:
Babies that are born before 30 weeks, weight less than 3 lbs at birth, or are high risk for other reasons should have retinal exams.
The first exam usually should be 4 - 9 weeks after birth, depending on the baby’s gestational age.
❖ Babies born at 27 weeks or later usually have their exam at 4 weeks of age.
❖ Those born earlier usually have exams later.
❖ Follow-up exams are based on the results of the first exam. Babies do not need another exam if the blood vessels in both retinas have completed normal development.
❖ Parents should know what follow-up eye exams are needed before the baby leaves the nursery.

Treatment of ROP:
❖ Laser Photocoagulation
❖ Cryotherapy
❖ Surgical management

Treatment of ROP: Laser Photo coagulation:
Zone – I: Any stage ROP with plus disease
Or
Zone – II: Stage 3, with or without plus disease
Or
Zone – III: Stage 2 or 3 ROP, with plus disease
Or

APROP

The following groups require frequent serial examinations (weekly/biweekly):

- Zone 1, stage 1 or 2 with no plus disease or
- Zone II, stage 3 with no plus disease

Preparation for laser therapy:

- Laser therapy is done on outpatient basis.
- The stomach should be decompressed before the procedure
- The baby should be examined before starting the procedure.
- During the procedure baby should be monitored by pulse oximeter. The resuscitation stethoscope should be ready.
- Baby should be re-examined at the end of the procedure.
- Observe the baby and monitor the vital signs for a minimum of 3 hours after the procedure.
- Complicated cases need cryotherapy or retinal reattachment.

Some babies with “plus disease” need immediate treatment.

- Laser therapy (photocoagulation) or cryotherapy (freezing) may be used to prevent complications of advanced ROP.
- The laser stops the abnormal blood vessels from growing.
- The treatment can be done in the nursery using portable equipment. To work well, it must be done before the retina develops scarring or detaches from the rest of the eye.
- Surgery is needed if the retina detaches. Surgery does not always result in good vision.

Long term Prognosis: Infants with significant ROP are at increased risk of high myopia, Anisometropia, other refractory errors, Strabismus, Amblyopia, astigmatism, late retinal detachment, glaucoma. Cicatricial disease refresh to residual scarring in the retina that leads later retinal detachment.

Stage 4 ROP with macular involvement has poor chance of good vision.

Screening procedure:

- Pupil dilatation
- Tropicamide 1%, 1 drop every 15 min, 4 times
- Phenylephrine 2.5%, 1 drop before the exam (1:4 dilutions)
- Pain relief
- No feeds before the procedure
- Sucrose, swaddling, restraint
- Paracetamol drops

Prevention:

The best way to prevent this condition is to take steps to avoid premature birth preventing other problems of prematurity may also help prevent ROP.

- Oxygen saturation targets (87% to 93%)
- PaO2 targets 50 to 70 mm of Hg
- Minimize oxygen duration and ventilation (permissive Hypervacnea)
- Minimize Blood transfusion (Strict Guidelines)
- Avoid Deficiency of Vitamin E
- Antenatal steroids

Summary:

- ROP is a blinding disease of prematurity
- VLBW infants or Gestation < 32 weeks should be screened
- Follow the 30 days rule
- Provide Pain Relief during the screening / laser
- Know the stage, zone, clock hours and plus disease

Bibliography:


Net references:

2. Confirm treatment plan - India’s only hospital managed by American medical experts retrieved from Http://www.American Opthalmology. Com/On 25.2/14 At 10:15 pm
Impact of intervention on signs, symptoms and management of Pre Menopause and menopause women.

“Menopause is a tough phase in a women’s life”, but she can make life as happy and productive as before, by adjusting to the changes in her body.

-Angela Gnanadurai

Women are the vital set up and heart of the family. When women have been tired, family function would be altered. Women are facing lot more problems through their life. One of the most common problem they are facing is menopause and hormonal changes during their middle adulthood. The menopausal problems of women always make them so tired. So they need treatment and health education regarding menopausal care and prevention of problems.

Pre menopause is the physiological termination of normal menstrual cycles. Pre menopause is generally caused more early than the normal age which is associated with the cessation of the menstrual cycles. Pre menopause occurs when the ovaries virtually stops producing the estrogen which generally leads the fertility aspect of the women to shut down

Because pre menopause is a very important period in women’s life; informed knowledge of what to expect will go a long way to prepare a woman for what is to come during menopause proper, especially because each woman’s transition from pre menopause to menopause may differ drastically due to the difference in the amount of the male hormone androgens that may be produced, which accounts for the devastating secondary male characteristics often exhibited by menopausal women.

Menopause is a natural process just as puberty is natural. Puberty prepares a girl to be able to conceive and bear children and menopause prepares women to cease to be able to conceive. Both cause sudden changes in one’s body, puberty by introducing hormones and menopause by withdrawing them. The term menopause is derived from two Greek words ‘meno’ and ‘pause’ meaning “month” and “stop”. Thus it is permanent cessation of menstruation.

According to Magent 2013 Indian Menopause Society research there are about 65 million Indian women over the age of 45. Average age of menopause in around 48 years but it strikes Indian women as fond as 38 to 43. So, menopausal health demands even higher priority in Indian scenario.

The percentage of women affected by Pre menopause symptoms vary widely. According to the American College of Obstetricians and Gynecologists, at least 85 percent of menstruating women have at least one Pre menopause symptom as part of their monthly cycle. Most of these women have symptoms that are fairly mild and do not need treatment. Some women (about three to eight percent of menstruating women) have a more severe form of PMS, called Premenstrual Dysphoric Disorder (PMDD).

Anitha (2005) study shows that majority of women (55.5%) had knowledge about the meaning of menopause and 36% had correct knowledge about the cause of menopause, which need to improve the overall knowledge of menopause. Mazhar. SB (2003) concluded 74.3% of women felt a need for health education on menopause.

Velasco-Murillo (2000) revealed that the most frequent climacteric symptoms were hot flushes (70.9%), depression (60.2%), insomnia (53.5%) and menstrual disturbances (37.8%). The women seeked medical care (51.1%) due to climatic symptoms but only (12.1%) received treatment, majority (81.6%) had taken hormones. In this survey (83.8%) of women had some knowledge about main symptoms of climacteric and (90.1%) knew about osteoporosis, but only (37.2%) had some knowledge about cardiovascular risk after menopause.

However, most remain unaware of the short and long term implications of the morbid conditions
associated with middle and old age due to lack of availability and increasing cost of medical and social system. Considering that Indian women now live between 10-20% of their lives in the post-menopausal state and postmenopausal women are known to have several health problems including osteoporosis, it is imperative that the public health care system gears itself to meet the challenges posed by their health needs, first as people live longer, the years after the menopause represent significant part of a woman’s life that she has every right to enjoy to the full. A woman’s state of health during those years depends a lot on her health before the menopause.

With the rising life expectancy world wide, significant proportion of women in the menopausal and post menopausal period will require special advice on women health strategies that will not only improve their quality of life, but will also allow them to objectively balance the benefits versus the risks of such strategies.

Though studies exist on menopausal women, only a few focused on the health of these women. Midlife is thus a time to focus on oneself and to seek resources from within the family and community to maintain and enjoy equilibrium. Women need knowledge about what to expect and how to cope with changes during menopause.

Hence the investigator has planned to conduct a study on impact of intervention in relation to signs, symptoms and management of Pre Menopause and menopause women.

**STATEMENT OF THE PROBLEM:** Impact of intervention on signs, symptoms and management of Pre Menopause and menopause women.

**OBJECTIVES OF THE STUDY**

- To assess the knowledge and practices of urban women on signs and symptoms of pre menopause and menopause in pre test and post test.
- To assess the knowledge and practices of rural women on signs and symptoms of pre menopause and menopause in pre test and post test.
- To evaluate the effectiveness of Intervention on knowledge and practices of urban women regarding signs and symptoms of pre menopause & menopause.
- To evaluate the effectiveness of Intervention on knowledge and practices of rural women regarding signs and symptoms of pre menopause and menopause.
- To compare the knowledge and practices of rural and urban women regarding signs and symptoms of pre menopause and menopause.
- To find out the association between the pre test and post test knowledge of urban women with their demographic variables.
- To see the association between the pre test and post test knowledge of rural women with their demographic variables.

**VARIABLES**

**Independent variable:**
Intervention on premenopausal and menopausal signs and symptoms.

**Dependent variable:**
Knowledge scores of rural and urban women on signs and symptoms of pre menopause and menopause.

**Extraneous variables:**
Age, locality, religion, education, occupation, annual income of the family, age of menarche, marital status, frequency of menstruation, duration of menstruation, number of children, history of abortion, use of contraceptives, history of breast feeding, age of menopause, history of menstrual abnormalities and history of hysterectomy of rural and urban women.

**RESEARCH APPROACH**

In the present study an evaluative research approach was considered as the best to determine the effectiveness of intervention on signs and symptoms of pre menopause and menopause.

**RESEARCH DESIGN:** One group pre test, post test design was adopted to assess the effectiveness of intervention on signs and symptoms of pre menopause and menopause among rural and urban women.

**SAMPLE:** Sample for the present study was women between the age group of 40-50 years residing in selected rural areas i.e. Chandragiri, Chittoor (Dt.) and urban areas i.e. Bommagunta, Balaji colony Tirupati, Chittoor(Dt.). The Sample consisted of 400 women between the age group of 40-50 years, of that 200 from rural area and 200 from urban area. Purposive sampling technique was used for selecting the subjects.
CRITERIA FOR SAMPLE SELECTION

Inclusive criteria:
- Women who are residing in selected rural and urban areas.
- Women between the age group of 40-50 years
- Women who were willing to participate in study
- Women who were present at the time of data collection
- Women who can able to speak, read and write in Telugu.

Exclusive criteria:
- Women who are not residing in selected rural and urban areas.
- Women less than 40 years of age
- Women who are not willing to participate in study.

RESEARCH TOOLS
- The study was carried out by using the following tools.

Questionnaire - I: Socio demographic data. It consists of age, locality, religion, education, occupation, annual income of the family, age of menarche, marital status, frequency of menstruation, duration of menstruation, number of children, history of abortion, use of contraceptives, history of breast feeding, age of menopause, history of menstrual abnormalities and history of hysterectomy of rural and urban women.

Questionnaire - II: Questionnaire related to knowledge on signs and symptoms of pre menopause and menopause. This consists of six parts.

Part - I: This part includes the questions to assess the knowledge of women between the age of 40-50 years regarding anatomy and physiology of menstruation.

Part - II: It contains questions related to basic concepts of menopause and meaning of menopause.

Part - III: It has questions related to causes of menopause.

Part - IV: This part explores the knowledge of women on signs, symptoms and diagnosis of pre menopause and menopause.

Part - V: This part includes the questions related to assess the knowledge of women on prevention of complications during menopausal transition.

Part - VI: It is related to assess the knowledge and management of menopausal syndrome.

SECTION – I

The demographic characteristics of urban and rural women.

Out of 200 urban women 40 percent were between the age group of 40 - 45 years, 55 percent were living in non slum areas, 45 percent were residing in slum areas. Majority of the women were Hindus with regarding to the education of the women, 45 percent had education up to 10th standard, 17.5 percent had degree and only 5 percent were coolies.

Twenty percent has an annual income of less than Rs.12,000 and majority of women had an annual income of Rs.12,000 to Rs.24,000. Majority of women expressed that they attained menarche between 12-14 years of age. Sixty percent were married, 20 percent were divorced and widowers. Forty five percent of women had 28th day as menstrual cycle, 64 percent of women had two to four days of menstrual flow noted, 72.5 percent of women had one to two children. With regards to use of contraceptives, 84 percent of the women had not used any contraceptives, 24 percent of them were not given breast feeding. Majority of the women attained menopause between 40-45 years of age, only 5 percent were above the age of 50 years. Among the menopause women, 35.50 percent are having history of abortion. In menopause women, 47 percent were suffering with dysmenorrhoea, 15.50 percent were suffering with menorrhagia and oligomenorrhea and 15 percent had hysterectomy. Out of 200 rural women, 30 percent were between the age group of 50-55 years, among them 60 percent are living in slum areas. Majority of women belongs to Hindus religion. Regarding education of women 70 percent were illiterate. Fifty percent of sample subjects were coolies getting annual income less than Rs 12,000 per year. Nineteen percent of women attained menarche above 40 years of age .The marital status of women indicates 65 percent are married, 30 were widowers and 5 percent were divorced. It is found that 25 percent had irregular menstrual cycle. Regarding the menstrual flow very less percentage of women had 7 days. 12.5 percent of women are not having children. Forty nine percent of women had two to four children, 28.5 percent of women have two to four children.
With regards to use of contraceptives, 90 percent of women had not used any contraceptive. Majority of women were given breast feeding and 47.50 percent attained menopause between age of 40-45 years, 33.50 percent women had abortion, 44 percent had history of menstrual abnormalities and 30 percent is having history of hysterectomy.

**SECTION II**
Knowledge of urban women regarding knowledge on signs and symptoms of pre-menopause and menopause in pre and post test

<table>
<thead>
<tr>
<th>Level of knowledge</th>
<th>Urban women (N=200)</th>
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<th>Post test</th>
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<td>N</td>
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Knowledge on practices and management of pre-menopausal syndrome among urban women in pre test and post test

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<th>Urban women (N=200)</th>
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<th>Post test</th>
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<tbody>
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Knowledge of rural women on signs and symptoms of pre-menopause and menopause in pre and post test

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Percentage showing the level of knowledge on practices and management of pre-menopausal syndrome among rural women in pre test and post test

<table>
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<th>Level of knowledge</th>
<th>Rural women (N=200)</th>
<th>Pre test</th>
<th>Post test</th>
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<tbody>
<tr>
<td></td>
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Section - IV
Effectiveness of intervention among urban women on knowledge and practices regarding signs and symptoms of pre-menopause and menopause

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<th>Post test Mean</th>
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<th>p value</th>
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**significant at 0.01 level

Section - V
Effectiveness of intervention among rural women on knowledge and practices regarding signs and symptoms of pre-menopause and menopause.

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<th>VARIABLE</th>
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Section - VI
Comparison of knowledge and practices on signs and symptoms of pre-menopause and menopause women in pre test by area.

<table>
<thead>
<tr>
<th>Urban women</th>
<th>Rural women</th>
<th>t value</th>
<th>p value</th>
<th>Sig</th>
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<td>Knowledge on practices</td>
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** & ** significant at 0.01 level

Comparison of knowledge and practices regarding signs and symptoms of pre-menopause and menopause women in post test by area.

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<td>Knowledge</td>
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<td>Knowledge on practices</td>
<td>9.19</td>
<td>1.34</td>
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<td>1.24</td>
</tr>
</tbody>
</table>

**significant at 0.01 level

Section - VII
Association between pre test level of knowledge and demographic variables of urban women.

There is a significant association between the knowledge of urban women in pre test with religion, education of the women, annual income, age at menarche, marital status, duration of menstrual flow...
of the women and history of breast feeding of the women and there is no significant association between the knowledge of urban women in pre test with age, locality, occupation of women, frequency of menstrual flow of women, number of children, use of contraceptives, age of menopause, history of abortion, history of menstrual abnormalities and history of hysterectomy of women.

SECTION VIII
Association between pre test knowledge and demographic variables of rural women.

It is found that there is a significant association between the knowledge of rural women in pre test with locality, religion of the women, annual income of the women, age of menopause and history of abortion of the women and there is no significant association between the knowledge of rural women in pre test with age, education, occupation of women, with age of menarche, marital status, frequency of menstrual flow, duration of menstrual flow of women, number of children, use of contraceptives, history of breast feeding, history of menstrual abnormalities and history of hysterectomy of women.

MAJOR FINDINGS OF THE STUDY
1. Majority of urban (88%) and rural (90.5%) women had inadequate knowledge in pretest and in post test 66% of urban and 58% of rural women had adequate knowledge after intervention on signs and symptoms of pre menopause and menopause.
2. In pre test 78.5% of urban and 83.5 % of rural women had inadequate knowledge on practices where as in post test 77.5% of Urban and 73.5% of rural women gained adequate knowledge on practices related to management of premenopausal syndrome.
3. Effectiveness of intervention on signs and symptoms of pre menopause and menopause was significant (P<0.001). As we know that health education will bring the changes in the behavior of the people. From the present study the results reveals that by giving awareness to the women regarding meaning, concepts, causes, signs and symptoms, complications, management and prevention of pre menopause and menopause the women can able to personalize the knowledge what they acquired and can change the life styles and do necessary modifications in their day to day life, so that they were free from the consequences of menopause and they will be going to maintain quality of life at their end stage.
4. The results of chi square test indicates in urban women religion, education, annual income, age of menarche, marital status, duration of menstruation, history of breast feeding were significant (P<0.05).
5. In pre test and in post test education, occupation, annual income, marital status, number of children, use of contraceptives, history of breast feeding and history of abortion were significant (P<0.05).

IMPLICATIONS OF THE STUDY
Today trend and present concept in the field of Obstetrics and Gynecology is family centered care and collaborative women with family.
The teaching that was planned for the study group proved to have a definite impact on the knowledge of women on signs and symptoms of pre menopausal and menopause. Gynaecologist, Nurses, human development specialist, Reproductive health care professionals, Asha workers, Anganwadi workers must plan similar educational programmes based on the needs of the women between the age of 40-50 years.
The meaning of Education is bringing the change in the behavior of the people. The current study also reveals that after intervention the women’s knowledge level has been improved which was the positive outcome. Reinforcement always needed for
each and every group hence as a nurses we should inform the health personnel who were close contact with the women regarding conduct of similar education programmes periodically that will enhance the quality of life of the women.

In India, there is no current health programme that calculate the specific reproductive health needs of aging women. RCH -2 (Reproductive and Child Health) and NRHM (National Rural Health Mission) programmes that are mean to comprehensively cover health concepts of women and children.

Health education regarding management of pre menopause and menopause will make the women residing in both urban and rural areas will improve their health and thereby make the women be happy in preceding days. Public health care system should mobilize resources and take necessary measures to improve the older women awareness and knowledge about menopause changes through educational training and guidance to maintain healthy life.

Nursing administration should initiate community awareness programme with active support of available resources in the community. Nurse administrators should begin in-service education for the gross root level workers regarding assessing the needs of the elderly women and prevention and management of problems faced by them. The nurses must have liaison with community health workers.

RECOMMENDATIONS

1. As the health education programme was effective in rural and urban areas similar health education programs were recommended for other communities also.
2. Similar study may be conducted pharmacological and non pharmacological therapies for managing the women in pre menopause and menopause period.
3. Master health checkups are recommended by the urban and rural women those who are in pre menopausal and menopause.
4. Awareness programme on post menopausal complications and its prevention an extensive research can be recommended.
5. Problems of early hysterectomy i.e. surgical menopause and its prevention an extensive study can be recommended.
6. Studies on menopausal women’s awareness on pap smear testing and warning signs of cervical cancer are recommended.
7. Studies related to Pre menopausal and menopausal women obesity management with yoga, exercise etc are recommended.
8. A research can also be conducted on post menopausal women suffering with osteoporosis.

REFERENCES:
CARE PROTOCOL FOR MANAGEMENT OF VARIOUS POISONING

Ms. Subadra Harikrishnan
MSc (N) Assistant Professor,
Dept. of Medical Surgical Nursing,
JMJ College of Nursing,
Sanath Nagar, Hyderabad.

Care of patient with poisoning in a Rural or Urban Home setting.
CARE PROTOCOL:
I. AIMS
- Maintain the airway breathing and circulation
- Identify the type of poison ingested
- Eliminate the poison immediately from the body
- Avoid the absorption of the poison, to make them less harmful.
- Transfer/shifting the patient to the hospital
II. OBJECTIVES:
Central objective:
To educate the community people about elimination of poison and take immediate measurement to save the life of the person who is affected, there by applying the general knowledge into practice.
Specific objectives:
The community health nurse is able to,
- define poisoning
- identify the types of poison consumed
- discuss the mechanism of action of poison.
- detect the signs and symptoms in patient after consumption of poison.
- give necessary care to them.
- eliminate the poison from the body
- make referrals
- educate patient and family members
- give advice to the family members about care of patient after discharge from the hospital.
III. METHODOLOGY:
After giving immediate remedy to the patient, interview the family members collect history find out the cause for consuming the poison, detect the complications at the earliest, get treatment and follow up services.

Protocol format
Identification data:
Name
Age
Sex
Father's name
Husband's name
House no
Village
Type of family
Type of house
Source of water supply
Type of latrine
Drainage system
Waste disposal
Economic status
Food habits and present condition
Type of poison consumed
Amount of poison consumed
Time interval

V. ASSESSMENT:
History:
- Did he/she consume the poison through swallowing Yes/No
- Is he/she received the poison injected through the skin Yes/No
- Did he/she inhaled the poison in industrial area Yes/No
- Is he/she had a habit of drinking alcohol Yes/No
- Had she/he attempted before Yes/No
- Is there any familiar problems he/she had Yes/No
- Had she/he drunk fluid after consume the poison Yes/No
- Did he/she feel metallic taste in the mouth Yes/No
- Did he/she have breathing difficulty Yes/No
- Did he/she a foam in the mouth after consume the poison Yes/No

Look for the presence of the following symptoms

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Signs and symptoms</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Acid poisoning (eg: nitric, sulphuric, hydrochloric and acetic acids)</td>
<td></td>
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<tr>
<td></td>
<td>- Burns around lips</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Burning in mouth, throat, heavy vomiting</td>
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<tr>
<td></td>
<td>- Intense thirst</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>Alkali poisoning (eg. Detergents, soda, ammonia, KOH, MAOH)</td>
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<tr>
<td>- Castor oil plant</td>
<td>- Aspirine overdose</td>
<td>- Acid poisoning</td>
<td>- Food poisoning</td>
</tr>
<tr>
<td>- Cannabis sativa</td>
<td>- Napothaline</td>
<td>- Alkali poisoning</td>
<td>- Petroleum distillators</td>
</tr>
<tr>
<td>- Dhatura</td>
<td>- Mushroom poisoning</td>
<td>- Mushroom poisoning</td>
<td>- Alcohol poisoning</td>
</tr>
<tr>
<td>- Aconite</td>
<td>- Insecticides</td>
<td>- Insecticides</td>
<td>- Cyanide</td>
</tr>
<tr>
<td>- Aconite</td>
<td>- Mushroom poisoning</td>
<td>- Mushroom poisoning</td>
<td>- Cyanide</td>
</tr>
<tr>
<td>- White yellow oleander (Kaner)</td>
<td>- Aspirine overdose</td>
<td>- Mushroom poisoning</td>
<td>- Cyanide</td>
</tr>
<tr>
<td>- Aconite</td>
<td>- Napothaline</td>
<td>- Insecticides</td>
<td>- Cyanide</td>
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<tr>
<td>- Aconite</td>
<td>- Mushroom poisoning</td>
<td>- Insecticides</td>
<td>- Cyanide</td>
</tr>
<tr>
<td>- Aconite</td>
<td>- Mushroom poisoning</td>
<td>- Insecticides</td>
<td>- Cyanide</td>
</tr>
<tr>
<td>VI. CLASSIFICATION OF POISONING</td>
<td>VII. ACTION TO BE TAKEN IMMEDIATELY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Loss of vision, cyanosis</td>
<td>- Resuscitate immediately</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Coma and shock</td>
<td>- Give plenty of water to drink if necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Food poisoning</td>
<td>- Induce vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Nausea and vomiting</td>
<td>- In mushroom poisoning-give castor oil to drink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Abdominal pain</td>
<td>- In metal poisoning milk-white egg, barley water,</td>
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</tbody>
</table>
First Aid Measures For Poisoning

- **Conscious**
  - No
    - Check ABC’s and treat accordingly.
    - Place on left side.
    - Seek medical attention.
  - Yes
    - Corrosive caustic
      - No
      - Give milk/water immediately.
      - Identify poison, how much and when taken.
      - Call poison control centre/other medical source.
      - Instruct to induce vomiting.
        - No
          - Give activated charcoal.
            - No
              - Premixed liquid form.
              - Gagging is ineffective, salt water is dangerous.
            - Yes
          - Yes
            - Syrup 4/4 ipecac.
              - Yes
                - Give 1 teaspoon for children under 8 years and 2 teaspoon for adults. Give a glass of water after the ipecac.
                - No
                  - After vomiting give activated charcoal.
                    - No
                      - Check ABC’s keep on left side to delay stomach emptying in to small intestine.
                    - Yes
                      - Premixed liquid form.
can be given.
- Shift the patient immediately to the hospital
- Decide what treatment has to give the person with consumer poison according to doctor’s prescription.
- The patient need emergency medical support.
- She/ he should referred to the clinic immediately

**HOME CARE TREATMENT**
- Give the treatment till total recovery
- Notify if any side effects
- Advice to take easy digestable food

**ANNEXURE 1**
**POISONING** : A poison also called a toxin, is a substance which, if taken into the body in sufficient quantity may cause, temporary permanent damage.

**ROUTE OF INGESTION :**
- Eating/drinking poisonous substance by mouth
- Inhaling house hold/industrial gases, chemical vapours, fumes from fire and exhaust by lungs
- By injection into the skin as a result of bites from animals, insects, snakes by hypodermic syringes.
- Absorption through skin by contact with poisonous sprays such as pesticides and insecticides.

**ANNEXURE 2**
**MECHANISM OF ACTION OF POISON**
- Swallowed ingested poisons, act directly on the food passages resulting in vomiting, pain and diarrhoea.
- Corrosive poisons may severely burn the lips, mouth, gullet, and stomach thus causing intense pain.
- Fumes and gases causes choking which may result in difficulty of breathing and unconsciousness.
- Some poisons work in the blood stream, central nervous system and prevent breathing, heart action and other vital life processes.
- Some poisons act by displacing the oxygen in the blood and preventing its distribution to the tissues.

**ANNEXURE 3**
- Inform the police
- Patient is to be removed from the offending agent like gaseous atmosphere.
- Collect information’s from the surroundings or persons available there to doctor.
- Preserve any suspecting material like a bottle containing pills/liquid for information to the treating doctor.
- If the person has vomited preserve the vomited materials also which can give some clues about the type of poison ingested.
- If the person is conscious and there are no burns, on lips or mouth then induce vomiting and preserve vomited material. Vomiting can be induced by fluids giving plenty of fluids, white of an egg/ milk and by touching the fauces ( inside the mouth).
- If the lips/ mouth shows signs of burning, cool them by giving the casualty water ( or) milk to drink. Do not induce vomiting.
- If the casualty is unconscious but breathing normally, place in the recovery position.
- If breathing and heart beat sign, begin resuscitation immediately.
- Shift to hospital immediately.
- Let person rest quietly and oxygen is available give this by mask for one hour.

**ANNEXURE 4**
**HEALTH EDUCATION**
- Household products and medicine should be kept out of reach and out of sight of children.
- Medicine should be spread separately from other household products and kept in their original container never in cups and soft drink bottles.
- All products should be turned on when giving/ taking medicine.
- A light should be turned on when giving/ taking medicine.
- Since children tend to intimate adults, adults should avoid taking medications in their presence.
- Medicine should be referred to by their correct names.
- Medicine cabinets should be cleaned out periodically.
- Use house hold substances in child resistant packaging. Prescription medicine should be contained in safety packaging.

**Documentation :**
After removal of the poison, monitor the condition of the patient record the viral signs consciousness, amount of poison removed, colour, consistency, urine output, type of poison should be documented.

**BIBLIOGRAPHY :**
Introduction:
Biological warfare has been existing since ancient times. Outbreaks of Plague, Smallpox, Cholera, Influenza has played a major role in decimating human population. Such catastrophes were described as “Evil spirits”, “wrath of God”, “deserving retribution to evil ways”.

Evolution of Chemical and Biological Weapons

Phase I: Gaseous chemicals like chlorine and phosgene were used in World War I.
Phase II: Use of nerve agents - Tabum and acholine - esterase inhibitors mark beginning of anthrax and plague in World War II.
Phase III: Herbicides were used causing crops destruction.
Phase IV: In recent time, biotechnological and genetic engineering revolutions are in progress.

Merits:
- Low cost-“Poor man’s atomic bomb”.
- Large quantities can be produced in short time with small facilities.
- Non detection by routine security system (biosensor), access to a wide range of agents and their dispersal can be made silently.
- Very toxic, hence small quantities will kill large number of persons.
- Destroys the enemy leaving his infrastructure intact as booty for the winter.

Demerits:
- Difficulty of protecting workers during production, transportation and delivery.
- Difficulty in maintaining quality control, contamination during growth and harvesting.
- Effective delivery system.
- May be destroyed after delivery.
- May disperse in unexpected ways aided by the wind.
- Need specific conditions for storage; hence difficult to maintain in weapons.
- Difficult to control once released.

Top Biological Weapons

❖ Bacillus Anthracis
- It is a gram positive organism, affecting sheep and cattle. Human get the disease either by inhalation of spores, where it is called Wool sorter’s disease (Pulmonary anthrax) or by cutaneous infection. Man to man transmission does not occur. Pulmonary anthrax is characterized by an incubation period of one day to eight weeks, flu like symptoms, abrupt onset of respiratory distress, cyanosis, shock, septicemia and death.
- Treatment is by ciprofloxacin, 400-800 mg, given IV twice a day.
- Vaccination is given by 6 subcutaneous doses at 0, 2 and 4 weeks, followed by 6, 12 and 18 months.
- Chemoprophylaxis is either by ciprofloxacin or doxycycline. Bacteria are extremely stable and can be stored as powder, used as aerosol sprays.

❖ Yersinia Pestis
- Results in plague, which is a zoonotic disease, disease of rodents, mainly rats, It is transmitted from rats to rats and rats to humans accidently by the bite of infected rat- fleas.
There are three forms of plaque - bubonic, pneumonic and septicemic, of which last two forms are serious.

- Useful antibiotics are streptomycin, Chloramphenicol, Doxycycline, Tetracycline and Sulphonamide.
- A formalin killed vaccine is available. Adult male 1.0 ml and 1.5 ml Female 0.75 ml & 1.0 ml with an interval of 1 to 2 weeks, Subcutaneous. Booster doses are recommended once in 6 months regularly who are at risk. Immunity develops after 1 week of inoculation and lasts for 6 months. Infants < 6 months and children do not require vaccination.
- The bacilli are used as an aerosol spraying biological weapon. It loses its infectivity quickly in aerosol preparation.

**Smallpox Virus**

- It is also called as variola virus. Smallpox has been declared eradicated by WHO in 1980. Since then vaccination has been discontinued. Virtually everyone is now susceptible and therefore feared as the greatest threat.
- Virus is highly infectious. Genetic recombination may enhance the virulence. The disease is characterized by high fever, followed by cutaneous eruptions in the stages of macules, papules, vesicles and pustules, which on drying leave behind permanent pock-marks. Case fatality rate being 40 percent.
- Effective chemotherapy is not available. Vaccine now exists only in selected WHO laboratories.

**Clostridium Botulinum**

- These bacilli are gram-negative, anaerobic and spore forming.
- The bacilli release an endotoxin, which is a powerful neurotoxin, resulting in a condition called Botulism, characterized by the paralysis of parasympathetic system, the features being ptosis, dysphagia, dysarthria, diplopia and constipation.
- Lethal doses of the toxin are 1-2 ng, which is absorbed from the intestine.

- Polyvalent antitoxin can neutralize the toxin. Immunization is by 3 doses of toxoid at 2 months interval.
- Contamination of food, water or aerosol is methods of Biological Weapon.

**Vibrio Cholerae**

- These bacteriae cause gastro-enteritis characterized by sudden onset of severe diarrhea, dehydration, acidosis, renal failure, shock and death by contamination of water and food.
- The best way of control of cholera is by providing chlorinated water supply to the community.
- Parenteral vaccine 1.0 ml single dose, I.M. Use of this vaccine after the outbreak of cholera is very short does not serve the purpose to control the epidemic because individual develops the antibodies after 15 days of immunization and incubation of cholera is very short, the individual may develop the disease much before he develops.

**Ebola virus**

- It is a highly contagious virus. These viruses target small capillaries, causing leak of blood and serum, 2-3 days after infection. Conjunctival hemorrhage and multi-organ failure ensues.
- These patients are treated by pressor agents, antiviral agents, fresh plasma and clotting factors. Incubation period and death is rapid. No vaccine is available.

**Mycotoxin:** This is the toxic product of fungi such as aspergillus, penicillium, fusarium which when contaminate grain and agriculture products, results in disease. It is usually delivered by air as “Yellow rain.”

It occurs by eating Amanita mushrooms. It produced five toxins in that amanitin, phalloidin are most potent hepatotoxins. Ergotamine causes purpura. Lysergic acid diethylamide cause vascular - neurologic effect.

Aflatoxins cause liver damage, hepatic carcinoma.
Newer Trends
➢ Products of microbes that can kill or incapacitate targeted hosts, e.g. Hormones, neuropeptides and cytokines, called as “designer substances” to target a particular organ or a type of enemy.
➢ Russia seems to have a new type of genetically modified anthrax or elude the vaccine used by America.
➢ Rumors are that Israelis are working to prepare “Ethnic bomb.”
➢ Parasite Biological Weapon is under trial to affect cash crops and cause huge economic loss.

Delivery of Biological Weapons:
➢ Scud missiles
➢ Motor vehicles with a spray
➢ Hand pump sprayers
➢ By an individual
➢ Book or letter
➢ Guns
➢ Remote control devices
➢ Robotic delivery

Combating Biological Weapons Incident / At Risk Group
The first responders are physicians, infectious disease specialists, epidemiologists, hospital and public health administrators and laboratory experts.

Steps to be Taken
➢ Detection: A microbiologic confirmation is needed.
➢ Case definition: To be formulated by health care personnel.
➢ Notification: To proper civilian and military authorities.
   - Natural – gradual rise in cases.
   - Terrorist - sudden rise in cases, in hours or days.
➢ Investigation: A quick identification of the source and consequence of the outbreak.
➢ Medical intervention: Diagnosis, Isolation and Treatment.
➢ Prophylaxis: Immunization of health care professionals and contacts - actively or passively.

Public awareness: It needs to be created to ensure that the incident does not turn into public hysteria.

Future Suggestions (Prevention and Control Measures)
➢ To create awareness among the public and health care professionals.
➢ To stock pile drugs and vaccine.
➢ Allocation of separate funds.
➢ Preparedness: This is not a cause for panic - It is a cause for serious, deliberate long-term concern.
➢ International collaboration is required as Biological Weapon do not respect “boundaries, culture, language or territory,” hence solution has to be global.
➢ Microbiologists are the main focal point of action, because the Biological Weapon is the products of their specialty.

Finally Conclusion:
➢ Biological warfare is reality . We have a large pool of microbiological technology. We have to put these resources into use. There is an urgency to develop out the bioterrorism capabilities of human, agricultural and veterinary bioterrorism. Hence we should have a clear vision, political will, careful planning and organization by integrating local, state and central capabilities and to remember that we can deal with bioterrorism and not overreact to it.

References:
“A study to assess the effectiveness of structured teaching programme on cervical cancer among the women at venkatachalam, Nellore”.

Mrs. N. Bayamma
Lecturer,
SVIMS College of Nursing,
Tirupathi.

INTRODUCTION:
“Cancer survivors are cancer overrides”
“Cancer ills often form strong wills”
Lethal chemo for the cancer evil”
“Cancer survived is a life revived”
Weissman, 2004; Cancer is a “Taboo” and the term cancer itself cause uneasiness to people who after believe it is untreatable. It takes up much of a person’s time in thinking about treatment and the future holds. During diagnosis and treatment, the magnitude of the problem becomes apparent which causes severe emotional and psychological problems like anxiety and depression which are inadequately managed and at times not even recognized.
Cervical cancer is a preventable disease as the different screening, diagnostic and therapeutic procedures are effective. At present through out the globe there are nearly one million women each year having cervical cancer. Cervical cancer is the most common cancer in women of the developing countries where screening facilities are inadequate (Dutta).

OBJECTIVES OF THE STUDY:
1) To assess the knowledge of women between 30 to 50 years regarding cervical cancer by pre-test.
2) To compare the pretest and post test scores of knowledge on cervical cancer among women at Venkatachalam, Nellore.
3) To associate the relationship between the post tests knowledge scores with socio Demographical data.

OPERATIONAL DEFINITIONS:
ASSESS: To evaluate the effectiveness of structure teaching programme on Cervical cancer among the women
EFFEC TIVENESS: Expected outcome of structure teaching programme on cervical Cancer among women.

STRUCTURE TEACHING PROGRAMME:
Referred to systematically planned and formulated teaching programme designed to provide information on cervical cancer among women.

CERVICAL CANCER: Cervical cancer is an abnormal growth, present in the mouth of the uterus.
WOMEN: 30 to 50 years female adults at Venkatachalam, Rural, Nellore.

HYPOTHESIS:
“There will be a statistically significant difference in the level of knowledge on cervical cancer among the women before and after the structured teaching programme.

Conceptual Frame Work

Modified conceptual frame work based on general system theory-1968

METHODOLOGY
RESEARCH APPROACH: An quasi experimental study will be utilized for exploring effectiveness of structure teaching programme on cervical cancer.

RESEARCH DESIGN: The study will be an quasi experimental design. The research design is the overall plan for organization of a scientific investigation.

SETTING OF STUDY: Venkatachalam Rural, area distance is from the Narayana College of Nursing to Venkatachalam is 20 kilometers, and 2kms away from the Swarna bharath trust, (Rural health centre) at Nellore.
POPULATION: The target population in this study includes all the women in the age group of 30 to 50 years and residing Venkatachalam, at Nellore.

SAMPLE: A sample of women (30 to 50 years) who are living in venkatachalam, at Nellore.

SAMPLE SIZE: A sample of 60 women between the age group of 30 to 50 years at Venkatachalam, Nellore.

SAMPLING TECHNIQUE: The simple random technique.

VARIABLES:

DEPENDENT VARIABLE: A prescribed effect is referred to as a dependent variable. The knowledge on cervical cancer among women is the dependent variable in this study.

INDEPENDENT VARIABLE: A presumed cause is referred to as an independent variable. The structure teaching Programme as cervical cancer is the independent variable in this study.

MAJOR FINDINGS OF THE STUDY:
The following were the major findings of the study: In assessing the knowledge on cervical cancer among women in pre-test; Among 60 samples, 7(11.6%) samples are poor knowledge; 52(86.7%) samples are average knowledge; and one women (1.7%) having good knowledge.

In assessing the knowledge on cervical cancer among women in post-test; Among 60 samples, 5(8.4%) samples are good knowledge; 55(91.6%) samples are excellent knowledge.

Comparison Of Mean And Standard Deviationin The Pretest And The Post Test Knowledge On Cervical Cancer Among Women. Comparison of pre-test and post-test knowledge on cervical cancer among women: shows there is a significant improvement between pre and post test knowledge. The mean value in pre-test is 13.58 with a standard deviation of 3.08, the mean value in post-test is 35.76 with a standard deviation of 3.34. And paired test value is 40.125 and the table value is 2.00 at d.f 59, it was significant at p< 0.05 level. The hypothesis is accepted.

Association of post-test knowledge scores among demographic variables: shows the association of post-test knowledge scores of women on cervical cancer by using chi-square it was found statistically there was no significance association between knowledge of women and their demographic variables such as age, education, occupation, religion, income, Gravida, family history. Source of health information regarding cervical cancer.

CONCLUSION:
The structured teaching programme was found to be effective for improving knowledge among women on cervical cancer. Conceptual frame work was selected for this study based upon the general system theory developed by Von Ludwing Bertalanfey, for structure teaching programme this model is facilitate the expression of the study.

RECOMMENDATIONS
❖ The study can be replicated with the large samples so that findings can be generalized.
❖ The study can be conducted video assisted programme on cervical cancer.
❖ The study can be conducted as a comparative study is between rural area and the urban area women.
❖ Structured interview questionnaire regarding cervical cancer can be included in the curriculum from the higher secondary school level.
❖ The study can be conducted for the women attending gynecology OPD in hospital setting.
❖ A study can be conducted to assess the attitude and practice related cervical cancer for women in rural area.

BIBLIOGRAPHY
3) Eenadu telugu news paper; Feb, 2010

JOURNAL REFERENCE:
COMPARISON OF READING SKILLS AMONG URBAN AND RURAL ELEMENTARY SCHOOL CHILDREN.

Ms. B. Byula Bavana,
M.Sc (N)Lecturer,
Dept. of Child Health Nursing
Kavuri Subba Rao College of Nursing, Guntur.

A comparative study was conducted to assess the reading skills among elementary school children Tirupati, Chittoor District, Andhra Pradesh. Cluster random sampling technique each school was considered as a cluster and children were selected by simple random sampling technique. The population selected for the study was boys and girls were studying 4th standard in Elementary schools, Tirupati. The sample size was 50 urban elementary school children and 50 rural elementary school children were selected. Structured interview schedule was administered to assess the Reading skills. The study revealed that out of 50 urban elementary school children 14% (7) below average, 56% (28) had average, and 30% (15) above average reading skills. Out of 50 rural elementary school children 52% (26) below average, 32% (16) had average, and 16% (8) above average reading skills. There is a significant deference in the levels of reading skills between urban and rural elementary school children at P<0.01. There was a statistically significant association exists between the levels of reading skills among urban elementary school children with their age, number of children in their family occupation of father, educational status of father and mother, type books like to read and time spent for reading at P<0.01 level and religion and distance between home and school at P<0.05 level.

INTRODUCTION:
The children of today are the future of tomorrow; this powerful statement assumes special significance of children (0-14 years) comprise one third of the total population in the country. Every child, on provision of a conducive and an enabling environment, may blossom into an ever fragrant flower, to shine in all spheres of life. This reminds us of the onerous responsibility that we have to mould and shape their present conditions in the best possible way.

Education is a powerful tool which prepares the children to become wise leaders. It makes them open to new ideas and become lifetime learners. One of the most important things that education can do for the youngsters is to open their minds.

Education is the fourth necessity for man after food, clothing and shelter, in today’s competitive world. The education is the process of instruction aimed at the all round development of individuals, providing the necessary tools and knowledge to understand and participate in day to day activities of today’s world. It dispels ignorance and boosts moral values of the individuals. It is the only wealth which cannot be robbed. It forms the basis for lifelong learning and inspires confidence to face challenges. It provides the skills to individuals to become more self reliant, enhances the ability to manage health and nutrition and plan for future.

Literacy in India is key for socio-economic progress, and the Indian literacy rate grew to 74.04% in 2011 from 12% at the end of British rule in 1947. Although this was a greater than six fold improvement, the level is well below the world average literacy rate of 84%, and of all nations, India currently has the largest illiterate population. Despite government programs, India’s literacy rate increased
only “sluggishly,” and a 1990 study estimated that it would take until 2060 for India to achieve universal literacy at then-current rate of progress. The 2011 census, however, indicated a 2001–2011 decadal literacy growth of 9.2%, which is the slower than the growth seen during the previous decade.

There is a wide gender disparity in the literacy rate in India: effective literacy rates (age 7 and above) in 2011 were 82.14% for men and 65.46% for women. The low female literacy rate has had a dramatically negative impact on family planning and population stabilization efforts in India. Studies have indicated that female literacy is a strong predictor of the use of contraception among married Indian couples, even when women do not otherwise have economic independence. The census provided a positive indication that growth in female literacy rates (11.8%) was substantially faster than in male literacy rates (6.9%) in the 2001–2011 decadal period, which means the gender gap appears to be narrowing.

Reading skill is essential to learning all subjects taught in school. The better the reading skills children have and the earlier they have them determines how rapidly and how well they will achieve in school. The first teacher any child has is his or her parent.

Reading is a basic life skill. It is a cornerstone for a child’s success in school, and, indeed, throughout life. Without the ability to read well, opportunities for personal fulfillment and job success inevitably will be lost.

Reading skills are specific abilities which enable the reader to read the written form as a meaningful language, to read anything written with independence, comprehension, and fluency and to mentally interact with the message.

Reading comprehension refers to the ability to understand text, and it is an important for elementary students. Good reading comprehension skills can help young children construct meaning from text, understand what they are reading, and improve their command of language.

The value of strong student reading skills is in having a purpose for reading. When children have a purpose for reading, they find that purpose not only directs their reading towards a goal, but helps to focus their attention. Purposes for reading may come from teacher directed questions, questions from class discussions, brainstorming with fellow students, or from the individual student. Along with a question, it is a good idea for the student to pose predictions of the outcome and problems which need to be solved. These may be generated by the student or the teacher, but the teacher should use these to guide students in the needed direction for the assigned selection. Students should also be organized before they read.

Children focus on learning to read in kindergarten through 2nd grade. After that, they read to learn, which means they read to extract information from texts. One of the main goals in 3rd-5th grade is for children to become enthusiastic, independent readers who can use their skills to learn new material in all subjects.

At least one in five children has significant difficulty learning to read. Evidence clearly demonstrates that most school-age children with reading difficulties fail to catch up with their peers. Although most of these children eventually become literate, many continue to have reading difficulties and never become fluent readers. Early development of reading skills is essential, and efforts should be made to identify children with reading disabilities and implement interventions at an early age. A child’s third-grade reading ability is reasonably predictive of overall long-term academic achievement. Seventy-five percent of children with reading disabilities who are not identified before the third grade continue to have reading disabilities in the ninth grade and fewer than 2 percent go on to participate in a four-year educational program after high school. Because children with reading difficulties often perform poorly in other areas of school, parents and teachers may not identify reading as the source. Therefore, children who have problems with school performance in any area should be assessed for reading difficulties.

According to a recent study published in Pediatrics, up to 50% of children with ADHD or ADD have reading disabilities. The 2011 Nation’s Report Card from the US Department of Education shows...
that 58% of fourth graders are not proficient readers. This statistic has remained unchanged since 2007.

**OBJECTIVES**
- To assess the reading skills among urban and rural elementary school children
- To compare the reading skills between rural and urban elementary school children
- To determine the association between reading skills of urban and rural elementary school children with the demographic variables.

**OPERATIONAL DEFINITIONS**
- **Reading skills**: Reading skills are specific abilities which enable the student to read the written form as a meaningful language, to read anything written with independence, comprehension, and fluency and to mentally interact with the message.
- **Elementary school children**: Those were studying 4th standard belonging to 9-10 years of age.

**ASSUMPTIONS**
- Urban children will have more reading skills than rural children.
- At the 4th standard children were going to study one more year in the same school, they could improve their reading skills.

**RESEARCH METHODOLOGY**: The study was comparative in nature and was conducted in elementary schools Tirupati, Chittoor District, Andhra Pradesh, South India. Cluster random sampling technique each school was considered as a cluster and children were selected by simple random sampling technique. The population selected for the study was boys and girls were studying 4th standard in Elementary schools, Tirupati. The sample size was 50 urban elementary school children and 50 rural elementary school children were selected. Structured interview schedule was administered to assess the Reading skills.

**Criteria for sample selection**

**Inclusion criteria:**
- Who can speak, read and write Telugu
- Age group of 9-10 years

**Exclusion criteria:**
- Children more than 10 years
- Children less than 9 years

**Tool description and scoring:**
It consists of 2 sections

**Section I**: Demographic profile. It includes age, gender, type of family, religion, place of residence, number of children in the family, distance between home and school, income, education and occupation of father and mother, social status of mother, habit of reading books, time spent for reading and how many times do you read to get comprehension.

**Section II**: Reading skills assessment tool

**Scoring**: The maximum total score was 25.
- < 50% below average, 50-70% average, 75% above average

**Method of Data collection**: Permission was obtained from M.E.O of Tirupati and head ministers of Elementary schools, Tirupati. The investigator was introduced to the group of 100 urban and 100 rural elementary school children from 4th standard, assigned for the study. Fifty urban and fifty rural children were selected on simple random sampling technique. They were divided into 10 urban and 10 rural groups. The data was collected from children by interview method. For each student 45 minutes was allotted for collection of data.

**Data analysis**: Descriptive statistics such as Percentage mean and standard deviation were used. Inferential statistics of chi-square test was used for analyzing the association between demographic characteristics of urban and rural school children with that of the tool scores. Paired ‘t’ test was used for analyzing the difference between the urban and rural schools.

**RESULTS**: Section-I Distribution of demographic variables among urban and rural elementary school children

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Demographic Variable</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>9 years</td>
<td>29</td>
<td>58</td>
</tr>
<tr>
<td>b)</td>
<td>10 years</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>c)</td>
<td>11 years</td>
<td>7</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>%</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>42</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Gender
- **a) Boy**: 28, 56, 30, 60
- **b) Girl**: 22, 44, 20, 40

### Type of family
- **a) Nuclear Family**: 34, 68, 25, 50
- **b) Joint family**: 16, 32, 16, 32
- **c) Single parent**
- **d) Extended family**: - , - , 9, 18

### Religion
- **a) Hindu**: 36, 72, 28, 56
- **b) Muslim**: 11, 22, 18, 36
- **c) Christian**: 3, 6, 4, 8
- **d) Any other**

### Place of residence
- **a) Urban**: 50, 100, 50, 100
- **b) Rural**
- **c) Semi urban**
- **d) Urban slums**

### Number of children in the family
- **a) One**
- **b) Two**: 33, 66, 31, 62
- **c) Three**: 15, 30, 15, 30
- **d) More than three**: 1, 2, 4, 8

### Distance between home and school
- **a) 1/2 KM**: 19, 38, 4, 8
- **b) 1 KM**: 21, 42, 34, 68
- **c) More than one kilometer**: 10, 20, 12, 24

### Occupation of father
- **a) Laborer**: 21, 42, 21, 42
- **b) Framar**: 6, 12, 16, 32
- **c) Employee**: 8, 16, 8, 16
- **d) Business**: 15, 30, 5, 10

### Occupation of the mother
- **a) Home maker**
- **b) Laborer**: 21, 42, 37, 74
- **c) Employee**: 13, 26, 13, 26
- **d) Business**: 4, 8, - , -

### Educational status of father
- **a) Illiterate**: 12, 24, 20, 40
- **b) Primary education**: 18, 36, 17, 34
- **c) Secondary education**: 5, 10, - , -
- **d) Collegiate**: 15, 30, 13, 26

### Educational status of mother
- **a) Illiterate**: 20, 40, 19, 38
- **b) Primary education**: 18, 36, 18, 36
- **c) Secondary education**: 10, 20, 5, 10
- **d) Collegiate**: 2, 4, 8, 6

### Do you have the habit of reading
- **a) Yes**: 50, 100, 50, 100
- **b) No**

### TABLE: 2 Distribution of scores of reading skills among urban elementary school children.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>Reading skills of urban elementary school children</td>
<td>7</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Reading skills of rural elementary school children</td>
<td>26</td>
<td>52</td>
<td>16</td>
</tr>
</tbody>
</table>

**Table:** 2 indicates that out of 50 urban elementary school children 14% (7) below average, 56% (28) had average, and 30% (15) above average reading skills. Out of 50 rural elementary school children 52% (26) below average, 32% (16) had average, and 16% (8) above average reading skills.
SECTION-III
Table-3: Comparison of reading skills between urban and rural elementary school children. Mean and standard deviation of urban and rural elementary school children reading skills scores.

<table>
<thead>
<tr>
<th>Sl.</th>
<th>Variables</th>
<th>Urban Mean</th>
<th>Urban Standard deviation</th>
<th>Rural Mean</th>
<th>Rural Standard deviation</th>
<th>Paired 't' Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Word attack skill</td>
<td>4.940</td>
<td>0.240</td>
<td>4.920</td>
<td>0.244</td>
<td>0.388</td>
</tr>
<tr>
<td>2.</td>
<td>Fluency</td>
<td>2.360</td>
<td>1.425</td>
<td>1.900</td>
<td>0.953</td>
<td>1.897</td>
</tr>
<tr>
<td>3.</td>
<td>Critical reading skill</td>
<td>4.460</td>
<td>1.249</td>
<td>3.720</td>
<td>1.400</td>
<td>2.789**</td>
</tr>
<tr>
<td>4.</td>
<td>Comprehension skill</td>
<td>1.660</td>
<td>0.848</td>
<td>1.380</td>
<td>0.753</td>
<td>1.746</td>
</tr>
<tr>
<td>5.</td>
<td>Reading with Comprehension</td>
<td>4.440</td>
<td>0.760</td>
<td>3.600</td>
<td>0.070</td>
<td>6.458**</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>17.920</td>
<td>3.116</td>
<td>15.500</td>
<td>3.005</td>
<td>3.953**</td>
</tr>
</tbody>
</table>

SECTION-IV
Association between reading skills of urban elementary school children with the demographic variables.

There was a statistically significant association between the levels of reading skills among urban elementary school children with their age, number of children in their family and education of father at 0.05 level and education of mother, time spent for reading and frequency of reading to get comprehension at 0.01 level.

Association between reading skills of rural elementary school children with the demographic variables.

There was a statistically significant association between the levels of reading skills among urban elementary school children with their age, gender, type of family, number of children in their family occupation of father, educational status of father and mother, type books like to read and time spent for reading at 0.01 level and religion and distance between home and school at 0.05 level.

DISCUSSION:
The study revealed that out of 50 urban elementary school children 14% (7) below average, 56% (28) had average, and 30% (15) above average reading skills. Out of 50 rural elementary school children 52% (26) below average, 32% (16) had average, and 16% (8) above average reading skills. There is a significant deference in the levels of reading skills between urban and rural elementary school children at P<0.01. There was a statistically significant association exists between the levels of reading skills among urban elementary school children with their age, number of children in their family and education of father at P<0.05 level and education of mother, time spent for reading and frequency of reading to get comprehension at P<0.01 level. There was a statistically significant association exists between the levels of reading skills among rural elementary school children with their age, gender, type of family, number of children in their family occupation of father, educational status of father and mother, type books like to read and time spent for reading at P<0.01 level and religion and distance between home and school at P<0.05 level.

CONCLUSION: Out of 50 urban elementary school children 14% (7) below average, 56% (28) had average, and 30% (15) above average reading skills. Out of 50 rural elementary school children 52% (26) below average, 32% (16) had average, and 16% (8) above average reading skills.

There is a significant deference in the levels of reading skills between urban and rural elementary school children at P<0.01. The data proved that the reading skills of urban elementary school children were higher than the rural elementary school children.

NURSING IMPLICATIONS

NURSING SERVICES:

Educational programmes are also an integral part of the medical services. Nurses should be
instrumental in helping the school children by teaching about the reading skills. The study showed that there was an impact of reading skills among elementary school children education. Nurses must plan for similar educational programmes based on the needs of the awareness among school children to improve their reading skills.

**NURSING EDUCATION:** In nursing schools and colleges, students should be trained in planning and implementing educational programmes.
- Teaching modules should be introduced in the curriculum of the primary level of nursing education.
- The students should be trained in putting their efforts to improve the reading skills among elementary school children and involve them in various national educational programmes.

**NURSING ADMINISTRATION**
- There should be an increase in the proportion of health care organization that provides family education on how to improve reading skills to their children.
- There should be an increase in the proportion of reading skills improvement measures.
- The nurse administrator should take interest in providing information regarding the need for organizing the education programs on reading skills. Planning and organizing such programs requires efficient team work strategies for optimum utilization of resources and focus on cost effective methods.

**NURSING RESEARCH**
- Nursing research on newer methods of teaching focusing on interest quality and cost effectiveness.
- There is a great need for nursing research in the areas of elementary school children education, particularly about reading skills.

**RECOMMENDATIONS**
- A longitudinal study could be conducted to see the reading skills among elementary school children from the beginning of academic year to completion of the year.
- Structured teaching programme was effective in school children, so structured teaching programme on improvement of reading skills could be initiated in all schools.
- A descriptive study on assessment of reading skills among elementary school children could be conducted at urban slums and semi urban areas.
- A comparative study could be done between private and government schools.
- School health personnel must prepare a self instructional material such as reading packages and video films on how to improve reading skills, which could be used in the schools periodically.

**REFERENCES:**
1. mospi.nic.in/Mospi_New/upload/Children_in_India_2012.pdf
11. http://lrs.ed.uiuc.edu/students/jblanton/read/readingdef.htm
A study to assess the effectiveness of structured teaching programme on prevention of selected puerperal infections among antenatal mothers attending MCH centre at Tirupati.

Guided by

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INTRODUCTION:

Becoming a mother is an important stage in every woman’s life. In addition to the time of expectancy and the actual delivery, the period immediately following child birth forms an integral part of the process. Maintaining good health during pregnancy and postpartum period is very important especially in the present stressful life. Puerperium, the period from delivery of the baby till 42 days, makes the women vulnerable in several ways. If mothers have adequate knowledge in postnatal care, puerperal infections can be prevented. To achieve and maintain health is increasingly valued as an individual’s responsibility. Enhanced learning needs, better knowledge and positive attitudes improve the self-care practices of the individuals.

Education and knowledge is very important for the safe motherhood. It is essential to educate the mothers properly to make them aware of the care before, during pregnancy and after delivery to prevent complications and reduce the maternal morbidity and mortality rate.

STATEMENT OF THE PROBLEM: A study to assess the effectiveness of structured teaching programme on prevention of selected puerperal infections among antenatal mothers attending MCH centre at Tirupati.

OBJECTIVES: The objectives of the study are

- To assess the existing level of knowledge on prevention of puerperal infections among antenatal mothers by conducting pre test.
- To evaluate the effectiveness of structured teaching program on prevention of puerperal infections among antenatal mothers.
- To find out the association between pre and post test knowledge of antenatal mothers on prevention of puerperal infections with their selected demographic variables.

RESEARCH HYPOTHESIS:

- H₁: There is a significant difference between pre-test and post-test knowledge scores of antenatal mothers on prevention of puerperal infections.
- H₂: There is a significant association between pre-test and post test knowledge score of antenatal mothers on prevention of puerperal infections with selected demographic variables.

CRITERIA FOR SAMPLE SELECTION:

Inclusion Criteria
Antenatal mothers who were:
- Both primi and multi gravid.
- Attending the MCH centre at Tirupati.
- Willing to participate in the study.
- Able to understand and speak Telugu.

Exclusion criteria
Antenatal mothers who were:
- Not willing to participate in the study.
- Not present at the time of data collection.
- Having psychological problems.
- Not able to understand and speak Telugu.

DEVELOPMENT AND DESCRIPTION OF THE TOOL:
The tool was developed based on review of literature, text books, journals, websites and with guidance of experts, consultation with the statistician for the plan of statistical analysis to assess knowledge on prevention of puerperal infections. The tool consists of two sections:

Section-I: This consists of socio demographic data such as mother’s age, religion, educational status, occupation, family income, type of family, place of residence, duration of marital life, parity, source of information and previous history of puerperal infection.
Section-II: This consists of 15 questions related to knowledge regarding prevention on puerperal infections. Among these, 5 questions had only one correct option remaining 10 questions had more than one correct option and the total score was 66. The same questionnaire was used to assess the knowledge levels of selected puerperal infections for both pre and post test.

METHODOLOGY: Pre experimental one group pre test and post test design was adopted for fifty antenatal mothers who were selected by convenient sampling technique at MCH centre, Tirupati, to evaluate the effectiveness of structured teaching programme on prevention of selected puerperal infections by structured questionnaire. Structured interview schedule and tool was used for data collection. Plexies, charts were used for structured teaching programme and after that post test was conducted.

RESULTS: In pre test out of 50 antenatal mothers 74% (37) had inadequate knowledge regarding prevention of puerperal infections, 22% (11) had moderate knowledge and 4% (2) had adequate knowledge, where as in post test 80% (40) mothers had adequate knowledge and 20% (10) had moderately adequate knowledge after structured teaching programme. This indicates that there is a significant improvement in knowledge on prevention of puerperal infections at P < 0.01 level. So H₁ hypothesis is accepted. Researcher revealed that there was significant association between the pre test knowledge and demographic variables such as mothers educational status, occupation, duration of marital life, are significant at P< 0.001 level and source of information is significant at P< 0.005 level. The association of post test knowledge score of subjects with demographic variables such as mothers educational status, monthly income of family, residence, are significant at P<0.001 level and mothers religion, duration of marital life, source of information are significant at P<0.005 level. Hence the research hypothesis H₂ stated that there will be significant association between pre and post test knowledge scores regarding prevention of selected puerperal infections among antenatal mothers with their selected demographic variables was accepted.

NURSING IMPLICATIONS:
Nursing Service: Several implications can be drawn from the present study for nursing practice.
- The expanded role of professional nurse emphasizes the activities which promote health.
- All health team members should be made aware of the need of observing, supervising, teaching and improving the knowledge and attitude of antenatal mothers on prevention of puerperal infections.

Nursing Education:
- In our nursing education curriculum, we are concerned in prevention and promotion aspects.
- The curriculum may be responsible for nurse’s knowledge in the field of obstetrics, but the nurse educators have the additional responsibility to update their knowledge by in service programmes.

Nursing Administration:
- Administrative department of nursing at various levels like institutional, local, state and national level should take stern measures to improve public awareness regarding puerperal infections.
- It is the duty of health administration, to make education department aware of existing health problems that is perinatal infections.

Nursing Research:
- Various methods may be used to strengthen the knowledge of people regarding prevention of puerperal infections by the researches.
- The result of the study indicate that the antenatal mothers had too lack adequate knowledge regarding puerperal infections and further insight into the existing situation will enlighten to understand the problem and definite way out.

CONCLUSION:
The present study revealed that antenatal women have inadequate knowledge regarding puerperal infections, and after structured teaching programme knowledge have improved among antenatal mothers.

REFERENCES
A study to assess the knowledge of mothers regarding care of low birth weight babies in Narayana Medical College Hospital, Nellore.

Ms. K. Ramya  
Assistant Professor Msc (N)  
Dept. of Pediatrics 
Narayana College of Nursing, Nellore.

INTRODUCTION:  
A low birth weight infant is defined as a live born infant weighing less than 2500 gm at birth. Low birth weight occurs in approximately 7% of live births of white infants. In black infants, the race is twice as high approximately 14%.

The low birth weight infants are 40 times more likely to die in the first 28 days of life than mature babies. Those who survive have an increased risk of mental retardation, cerebral palsy, recurrent convulsions, delayed speech, blindness and deafness. Low Birth Weight is associated with fetal and perinatal mortality and morbidity, inhibited growth, cognitive development and chronic diseases later in life, at the population level the proportion of babies with a low birth weight is an indicator of a multifaceted public health problem, that includes long term maternal malnutrition, ill health, hard work and poor health care in pregnancy.

PROBLEM STATEMENT: A study to assess the knowledge of mothers regarding care of low birth weight babies in Narayana medical college hospital, Nellore.

OBJECTIVES:  
1. To assess the knowledge regarding care of low birth weight babies among mothers in Narayana Medical college hospital, Nellore.  
2. To associate the level of knowledge with socio demographic variables of mothers Narayana Medical college hospital, Nellore.

METHODOLOGY  
Research approach: A Quantitative research approach  
Research design: The research design used for this study is descriptive research design.

Setting of the study: The study was conducted in Narayana Medical College Hospital, Nellore.

Target population: The target population of the study is post natal mothers and mothers of under five children.

Accessible population: The assessable population of the study is post natal mothers and mothers of under five children in Narayana Medical College Hospital, Nellore.

Sample: The sample for the present study include the mothers of low birth weight babies and under five children in Narayana Medical College Hospital, Nellore and who fulfill the inclusion criteria.

Sample size: The sample size of the study is 30 post natal mothers and mothers of children.

Sampling technique: Convenience sampling technique was used to select the subjects.

Criteria for sample selection  
Inclusion criteria:- The inclusion criteria for the present study were the following,  
• Mothers who are having under five children.  
• Mothers who are having low birth weight babies.  
• Mothers who are willing to participate in this study.

Exclusion criteria:-  
• Mothers who are not willing to participate in this study.

Method of data collection: For the study
questionnaire method was used to assess the knowledge regarding care of low birth weight babies in Narayana medical college hospital, Nellore.  

**The tool consist of two parts.**

**PART 1:** Deals with demographic data.

**PART 2:** Consist of two sections.

**SECTION A:** Deals with the demographic variables of the mother such as age, education, occupation, income, type of family and marital status.

**SECTION B:** Deals with structured questionnaire with 30 questions.

**PILOT STUDY:** After obtaining formal permission from the medical superintendent of Narayana Medical College Hospital, Nellore, the pilot study was conducted. The investigator selected three mothers in the pilot study. The investigator assess the knowledge based on the questionnaire. Pilot study concluded that tool is reliable for conducting main study.

**DATA COLLECTION PROCEDURE:**

After obtaining permission from the concerned authorities the data collection procedure was carried out. The purpose of questionnaire schedule was explained to the mothers and good interpersonal relationship was established. The subjects were selected by using simple random sampling technique. Data was collected by using questionnaire to assess the knowledge regarding care of low birth weight babies among mothers of under five children. The data collection procedure was carried out for a period of 1 week.

**PLAN FOR DATA ANALYSIS:**

The data was analyzed by using descriptive and inferential statistics.

- Frequency and percentage distribution of demographic variables.
- Range of score, mean, standard deviation
- Chi square was done to find out the association between knowledge of mothers regarding care of low birth weight babies.

**ASSOCIATION BETWEEN THE LEVEL OF KNOWLEDGE OF MOTHERS REGARDING CARE OF LOW BIRTH WEIGHT BABIES WITH SOCIODEMOGRAPHIC VARIABLES**

(N=30)

<table>
<thead>
<tr>
<th>Socio Demographic Variables</th>
<th>Inadequate</th>
<th>Average</th>
<th>Adequate</th>
<th>CHI-Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>%</td>
<td>f</td>
<td>%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. 21 -29 years</td>
<td>11</td>
<td>36.7</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>b. 30 -35 years</td>
<td>2</td>
<td>6.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. 36 -40 years</td>
<td>2</td>
<td>6.7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>d. Above 40 years</td>
<td>1</td>
<td>3.3</td>
<td>2</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>a. Primary</td>
<td>10</td>
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<tr>
<td>b. Secondary</td>
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<td>16.7</td>
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<td>c. Intermediate</td>
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<td>d. Degree</td>
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### Occupation

<table>
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<th>Average</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a. House wife</td>
<td>11</td>
<td>36.7</td>
<td>3.3</td>
</tr>
<tr>
<td>b. Teacher</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Shop keeper</td>
<td>1</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>d. Coolie</td>
<td>4</td>
<td>13.33</td>
<td>3.3</td>
</tr>
</tbody>
</table>

- **C= 10.50**
- **T=12.59**
- **df = 6**

### Income

<table>
<thead>
<tr>
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<th>N</th>
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<tbody>
<tr>
<td>a. 5000-7000RS/-</td>
<td>14</td>
<td>46.7</td>
<td>3.3</td>
</tr>
<tr>
<td>b. 7000-9000RS/-</td>
<td>1</td>
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<td>0</td>
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<tr>
<td>c. 9000-11000RS/-</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Above 11000RS/-</td>
<td>1</td>
<td>3.3</td>
<td>0</td>
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</tbody>
</table>

- **C= 11.04**
- **T=12.59**
- **df = 6 NS**

### Type of family

<table>
<thead>
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<th>N</th>
<th>Average</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a. Nuclear family</td>
<td>10</td>
<td>33.3</td>
<td>26.7</td>
</tr>
<tr>
<td>b. Joint family</td>
<td>4</td>
<td>13.33</td>
<td>3.3</td>
</tr>
<tr>
<td>c. Extended family</td>
<td>2</td>
<td>6.7</td>
<td>10</td>
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</table>

- **C= 4.72**
- **T=9.49**
- **df = 4 NS**

### Religion

<table>
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<th>Religion</th>
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<th>Average</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Hindu</td>
<td>13</td>
<td>43.3</td>
<td>20</td>
</tr>
<tr>
<td>b. Muslim</td>
<td>2</td>
<td>6.7</td>
<td>13.3</td>
</tr>
<tr>
<td>c. Christian</td>
<td>1</td>
<td>3.3</td>
<td>6.7</td>
</tr>
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</table>

- **C= 5.782**
- **T=9.49**
- **df = 4 NS**

NS**-Non significant N-Sample size C- Calculated value T-Table value

### MAJOR FINDINGS OF THE STUDY

- Out of 30 mothers 12(40%) mothers had average knowledge, 16(53.3%) mothers had inadequate knowledge and 2(6.7%) of mothers had adequate knowledge regarding care of low birth weight babies.
- Majority of respondents 19(63.3%) were between 21-29 years of age.
- Majority of respondents 14(46.7%) had primary education.
- Majority of respondents 20(66.7%) were housewives.
- Majority of respondents 21(70%) had income of 5000 - 7000 Rs/-. 
- Majority of respondents 18(60%) were belongs to nuclear family.
- Majority of respondents 20(66.7%) were belongs to Hindu religion.
- Majority of respondents, 16(53.3%) mothers have inadequate knowledge.
- There was significant association between the level of Knowledge and education of mothers.

### NURSING IMPLICATIONS

The most effective way to improve the care is provide guidance to the subjects regarding regularly the need of adherence the treatment regimen.

- Educate the mothers about care of low birth weight babies and prevention.
- Encourage the mothers of low birth weight babies and underfive childrens trying to change the unhealthy life style.
- Advice the mothers to give kangaroo mother care.
- Encouraged the mothers to give exclusive breast feeding.
- Educate regarding the follow up care.
NURSING SERVICES
The best method of preventing the of low birth weight babies is to promote breast feeding, kangaroo mother care, health check up and health education.

NURSING ADMINISTRATION
- The number of health care organization that provides family education is to prevent low birth weight babies.
- The local health department that have established competent health promotions and care of low birth weight babies and prevention programs.
- The in service training to all health personal is to be assured.

NURSING EDUCATION
Awareness programmes discussion, Health camps, Seminars and role plays can be conducted for improving the knowledge attitude, management and practice regarding care of low birth weight babies among mothers of low birth weight babies and under five children.

NURSING RESEARCH
Researcher should aims on the knowledge regarding care of low birth weight babies among mothers of low birth weight babies and under five children and more studies can be done to improve attitude, practice and knowledge regarding care of low birth weight babies among mothers of low birth weight babies and under five children.

NURSING PRACTICE
- Nurse has been responsibility to educate the prevention of low birth weight babies.
- Nurse should be providing adequate nursing care to such low birth weight babies.

CONCLUSION
- The findings of the study revealed that Majority of mothers have inadequate Knowledge. Educational program me to be organized or prevention of low birth weight babies to improve the knowledge of mothers of low birth weight babies and under five children to reduce the prevalence of low birth weight babies.

BIBLIOGRAPHY

JOURNALS REFERENCE
3. P. Muthumari(2010), Effectiveness of structured teaching among mothers of under five children, Nightingale nursing times, Ashok jain publications, Vol(6) 3
4. Karuna Sharma(2012), Mothers knowledge of care of obesed babies, Nightingale nursing times, Ashok jain publications, Vol(8) 9
**Importance:** Human milk is specifically designed for human babies and provides unique benefits that cannot be duplicated by formula. Babies who are born prematurely are at a higher risk of gastrointestinal diseases and infections. Often, moms are not able to supply their babies with the milk they need because they are under great stress or are ill themselves. Human milk provides babies with antibodies to fight disease and infection and also protects against allergies. Providing these fragile infants with pasteurized human donor milk provides them with passive immunity and gives them a stronger hold on life.

**Aim:** To ensure quality of donated breast milk as a safe end product.

**Introduction:** Breastfeeding is the best method of infant feeding because human milk continues to be the only milk which is tailor-made and uniquely suited to the human infant. All mothers should be encouraged to breast-feed their infants. When a mother, for some reason, is unable to feed her infant directly, her breast milk should be expressed and fed to the infant. If mother’s own milk is unavailable or insufficient, the next best option is to use pasteurized donor human milk (PDHM). India faces its own unique challenges, having the highest number of low birth weight babies, and significant mortality and morbidity in very low birth weight (VLBW) population. In our country, the burden of low birth weight babies in various hospitals is about 20% with significant mortality and morbidities. Feeding these babies with breast milk can significantly reduce the risk of infections. Hence the Government, health experts and the civil society must join hands to propagate the concept of human milk banking for the sake of thousands of low birth weight and preterm babies.

A human milk bank is “a service which collects, screens, processes, and dispenses by prescription human milk donated by nursing mothers who are not biologically related to the recipient infant”. (3) As of March 2014, there are 16 milk banks in North America. (4) They are usually housed in hospitals, although some are free standing. They are members of the Human Milk Bank Association of North America (HMBANA) and voluntarily abide by HMBANA’s annually revised “Guidelines for the Establishment and Operation of a Donor Human Milk Bank.” The guidelines were developed with the Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) and include protocols for soliciting donors, collecting, processing and distributing the milk.
History
Donation of breast milk from one woman to an unrelated infant has a long history. Before this century, the infant would have been directly breastfed by the woman who was referred to as a “wet nurse”. Rules governing wet nursing have been around since 1800 BC. Wet-nursing itself has had periods throughout history when it has fallen from favor. For example, in the 15th century, wet nursing became very unpopular due to the spread of syphilis.

Human milk banking has had similar peaks and troughs. In the early half of this century, milk banking saw resurgence in popularity, but around the 1970s, this began to change. The first reason for this loss of interest in human milk was the heavy promotion of infant formula, including formulas specially designed for preterm infants. Later, a fear of transmission of viruses, including HIV, in body fluids led to an anxiety about donation of body fluids, including breast milk.

International statement
WHO and UNICEF, made a joint statement in 1980: “Where it is not possible for the biological mother to breast feed, the first alternative, if available, should be the use of human milk from other sources. Human milk banks should be made available in appropriate situations.”

Banked human milk Uses
Banked human milk is regarded as “the next best” after the biological mother’s breast milk. It is used for the treatment of many conditions (mainly in Neonatal Intensive Care Units: NICUs): prematurity, malabsorption, short-gut syndrome, intractable diarrhea, nephrotic syndrome, some congenital anomalies, formula intolerance, failure to thrive, immune deficiencies (IgA).

Studies have found that breast milk has a protective effect against necrotizing enterocolitis (NEC). Lucas and Cole found that NEC was 3 times more likely when formula-only fed infants were compared to those receiving both breast milk and formula. Other studies have demonstrated that formula fed infants had lower IQ scores than infants fed breast milk. Milk banks vary in their use of banked milk. In some cases, milk is provided for adopted babies or older children with severe food allergies.

If PDHM supplies are sufficient donor milk may be supplied for:
• Absent or insufficient lactation: Mothers with multiple births, who cannot secrete adequate breast milk for their neonates initially.
• For babies of non-lactating mothers, who adopt neonates and if induced lactation is not possible.
• Abandoned neonates and sick neonates.
• Temporary interruption of breastfeeding.
• Infant at health risk from breast milk of the biological mother.
• Babies whose mother died in the immediate postpartum period.

Who can donate?
A lactating woman who:
• Is in good health, good health-related behavior, and not regularly on medications or herbal supplements (with the exception of prenatal vitamins, human insulin, thyroid replacement hormones, nasal sprays, asthma inhalers, topical treatments, eye drops, progestin-only or low dose estrogen birth control products);
• Is willing to undergo blood testing for screening of infections; and
• Has enough milk after feeding her baby satisfactorily and baby is thriving nicely.

Who cannot donate?
A donor is disqualified who:
• uses illegal drugs, tobacco products or nicotine replacement therapy; or
• Regularly takes more than two ounces of alcohol or its equivalent or three caffeinated drinks per day; or
• Has a positive blood test result for HIV, HTLV, Hepatitis B or C or syphilis; or
• Has received organ or tissue transplant, any blood transfusion/blood product within the prior 12 months.
• Is taking radioactive or other drugs or has chemical environmental exposure or over the counter prescriptions or mega doses of vitamins, which are known to be toxic to the neonate and excreted in breast milk; or
• Has mastitis or fungal infection of the nipple or areola, active herpes simplex or varicella zoster infections in the mammary or thoracic region.

Screening donors: Milk donors are new mothers who are in good health, whose infants are growing, thriving, and under six months old when they begin (Arnold, 1997). Because there is some risk of passing infections and viruses to babies through breast milk, donors must undergo a medical screening and a blood test to rule out infectious diseases such as HIV-1 and-2, hepatitis B and C and syphilis(Arnold, 1997).

COLLECTION OF BREASTMILK
After proper counseling, checking suitability for donation, getting written informed consent, history taking, physical examination and sampling for laboratory tests, the donor is sent to designated breastmilk collection area in the milk bank or in the milk collection center. Breastmilk is collected by trained staff with hygienic precautions, after method of breastmilk expression is chosen by the donor.

EQUIPMENTS
Pasteurizer/Shaker-water bath, Deep freezer, Refrigerators, Hot air oven/Autoclave, Breastmilk pumps, Containers, Generator/Uninterrupted power supply, Milk analyzer

GENERAL GUIDELINES FOR STAFF OF THE HUMAN MILK BANK
• Standard operating procedures (SOP) of the bank (which should be displayed at proper places) should be adhered to.
• Hygienic practices like proper hand wash, donning gowns, mask, gloves, trimming nails, locking long hairs should be maintained.
• Gloves should be worn and changed between handling raw and heat-treated milk.
• Staff should undergo regular health checks and be immunized against Hepatitis B.
• There should be a program for ongoing training of the staff.

Storage and Dispatch
The American milk bank guidelines give clear recommendations regarding these practical issues. Fresh-raw milk must be stored continually at 4 degrees Celsius for no longer that 72 hours following expression, whereas fresh-frozen milk can be held at 20 degrees Celsius for 12 months. Heat-treated (pasteurized) milk may be stored under the same conditions as fresh milk.

UNICEF supports countries to implement the priority actions outlined in the Global Strategy for Infant and Young Child Feeding. The focus in countries is on five major areas:
1. **At national level:** ensuring that not only appropriate policies and legislation are in place but that these are implemented and enforced. This includes support for:
   - Development and implementation of national infant and young child feeding policies and strategy frameworks.
   - Development and implementation of programme plans to operationalize the strategy.
   - Development and enforcement of appropriate legislation (such as the International Code of Marketing of Breast milk Substitutes and maternity protection legislation).
   - Encouraging and facilitating strategic public and private partnerships with other international and country-level actors for improvement of infant and young child nutrition.

2. **Health system level:** support is provided to institutionalize interventions in the health system, such as the Ten Steps to Successful Breastfeeding and the Baby-Friendly Hospital Initiative (BFHI), curricula, training and support of health workers and health information systems. Resources, jointly produced with the World Health Organization, include the BFHI training course and an Integrated Course on IYCF Counseling.

3. **Community level:** support is provided for community-based IYCF counseling, communication and mother support activities involving for example community health workers, lay counselors and mother to mother support groups.

4. **Communication and advocacy** activities on breastfeeding are also a key component of UNICEF support. UNICEF supports countries to conduct formative research, which is used to feed into the design of strategies for social and behavior change communication, and UNICEF supports the implementation of the strategies through multiple communication channels.

5. **IYCF in especially difficult circumstances:** UNICEF supports interventions to address infant feeding in emergencies and infant feeding in the context of HIV/AIDS. Breastfeeding Saves More Lives Than Any Other Preventive Intervention!

**CONCLUSION**

It is clear that artificial formula will never provide the broad range of benefits of human milk. Given the high rate of preterm births in the country and level of malnutrition that ensues in the postnatal growth in such after birth, there is an urgent need to establish milk banks across the country, especially in the large neonatal units of all hospitals.

**REFERENCES**

8. Dr Carolyn Nash and Dr Lisa Amir for the Maternal and Child Health Sub-committee.
“A study to assess the knowledge about growth and development of toddlers among mothers of toddlers in selected rural area of Nellore”.

Ms. Ruth Grace. M
M.Sc (N), Lecturer
Pediatric Nursing,
Sree Narayana Nursing College, Nellore.

INTRODUCTION:
Child is a God’s gift for a family. Children are more vital, more gentle, more joyous, more trustful, more curious, more courageous and more innovative than adult. Children bring happiness and make a family as a whole. Children’s health forms major component of family health. It depends upon the family’s physical and social environment, which includes its lifestyles, custom, culture, traditional habits and especially child rearing knowledge which involves the knowledge regarding growth and development. Children’s health reflects the national health and wealth. Today’s children are tomorrow’s citizen. A well developed child’s contribution to the national welfare is a priceless resource of nation. Children are embodiment of our dreams and the hope for the future. They are the most vulnerable group in the society. Children have been specifically studied because their status is a sensitive indicator of health. Healthy children grow to become healthy adults, who are strong both in body and mind.1,6

Growth and development usually refers to a unit and is expressed as the sum of the numerous changes that take place during the life time of an individual. Growth is a process of physical maturation resulting on increase in size of the body and various organs. It occurs by multiplication of cells and an increase in intracellular substance. It is a quantitative change of the body which can be measured in inches/centimeters and pounds/kilograms. It is a progressive and measurable phenomenon.1

Development is a process of functional and physiological maturation of the individual. It is progressive increase in skill and capacity to function. It is related to maturation and mylenation of the nervous system. It includes physical emotional and social changes. It is a qualitative aspect of maturation and is difficult to measure. It is orderly, not haphazard and is having direct relaxation between each stage and the next. Development involves physical (Gross motor, Fine motor, Visual and Hearing), cognitive (Language, Solve problems, Gain knowledge) and emotional development.2

A toddler is a young child who is of age of learning to walk between infancy and childhood. Toddling usually begins between the age of 12 months and 24 months. During the toddler stage, the child also learns a great deal about social roles, develops motor skills and first starts to use language.2

The first three years of life are of prime importance from the development point of view, so care during this stage has crucial influence on child’s growth and development. Especially rural mothers are ignorant about essentials of child care in terms of nutritional requirements, healthcare, feeding and weaning practices etc. Feeding especially in the early years of life has a lifelong effect since varying degrees of growth retardation has been observed in infants and children because of under nutrition and malnutrition. So highest priority should be given to childcare developmental program because the progress and prosperity of a country depends on the care given to children.3

A cross sectional study was conducted in India to assess the knowledge, attitude and practice of mothers regarding, parenting of children less than three years of age. The samples were 120 mothers, who had children less than three years of age. 60 mothers were from rural areas. The mothers were interviewed in their homes using structured questionnaire on knowledge. Percentages were calculated to assess the knowledge, attitude and practices of mothers regarding parenting. More urban mothers (70%) followed healthy practices in parenting than rural mothers (36.7%) in the areas of...
physical growth such as hugging and praising as the means of reward to their children, telling stories to their children and providing educational toys. Regarding social development and psychological aspects of parenting, urban mothers (40%) had a favorable attitude than rural mothers (20%). The study concluded that, there was no significant association between rural and urban mothers regarding their knowledge in parenting.4

A study was conducted in Himachal Pradesh, India to provide educational intervention to mothers regarding on child care. The study adopted a pretest and posttest research design. A total sample of 150 mothers was selected from two villages. One of which served as experimental group and other acted as control group. The total tool consisted of a self structured questionnaire schedule covering aspects of child care and nutrition. All mothers were first pre-tested regarding their knowledge on nursing, child care, growth and nutritional aspects. Intervention consisted of educating mothers in the experimental group for a period of one and a half years. All mothers were then post tested on the above aspects. The result of study revealed that there was significant difference in all the aspects of child care and nutrition between experimental and control group mothers during posttest. The study concluded that experimental group mothers have more knowledge than control group.5

OBJECTIVES:
▲ To assess the knowledge of the mothers regarding the growth and development of the toddlers.
▲ To associate the level of knowledge with selected sociodemographic variables.

METHODOLOGY:
The research design selected for this study is non-experimental descriptive design. The study is conducted in Venkatachalem, Nellore. The sample for the study is selected with non probability convenience sampling technique and includes 60 mothers of toddlers who fall under inclusion criteria.

SAMPLING CRITERIA:
1. Mothers of toddlers at Venkatachalem, Nellore.
2. Mothers who can read and write either in Telugu or English.

Exclusive criteria:
1. Mothers who are not willing to participate in this study.
2. Mothers of toddlers with developmental problems.

DESCRIPTION OF THE TOOL:
Section - A: Socio Demographic variables: It includes age, religion, education, occupation, income, type of family, number of children in family and residence.
Section - B: Questionnaire related to knowledge on growth and development of toddlers.

DATA COLLECTION PROCEDURE:
Data collection period was for four weeks. Permission was obtained from Panchayat officer of Venkatachalam to conduct the study. Sample is informed by the investigator about the nature and purpose of the study and then the consent was obtained. Information was obtained through the questionnaire.

DATA ANALYSIS: Data analysis is done with descriptive and inferential statistics.

Table 1: Percentage distribution of mothers of toddlers based on age.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Age in Years</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Below 20</td>
<td>17</td>
<td>28.3%</td>
</tr>
<tr>
<td>2</td>
<td>21 - 30</td>
<td>25</td>
<td>41.7%</td>
</tr>
<tr>
<td>3</td>
<td>31 - 40</td>
<td>15</td>
<td>25%</td>
</tr>
<tr>
<td>4</td>
<td>Above 40</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 1 shows that among the 60 mothers of toddlers related to age, 17(28.3%) belong to the age group below 20 years, 25(41.7%) belong to 21-30 years, 15(25%) belong to 31-40 years age group and 3(5%) belong to above 40 years age group.

Figure 1: Percentage distribution of mothers of toddlers based on no.of children.
**Figure 1** shows that there are 32(53.3%) mothers of toddlers with only one child, 16(26.7%) with 2 children, 7(11.7%) with 3 children and 5(8.3%) with 4 or more children.

**Table 2:** Knowledge scores of mothers of toddlers

<table>
<thead>
<tr>
<th>S.No</th>
<th>Level of Knowledge</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Adequate</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>2.</td>
<td>Moderately adequate</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>3.</td>
<td>Inadequate</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

The study revealed that the education, type of family and no. of children had significant association with level of knowledge of mothers of infants and age, religion, occupation, income and residence have non-significant association with level of knowledge of mothers of infants regarding growth and development of the toddlers.

**DISCUSSION:**

The study revealed that out of 60 mothers of toddlers, 50 %(30%) had adequate knowledge, 30% (18) had moderately adequate knowledge and only 20% (12) had inadequate knowledge and education, type of family and no. of children had significant association with level of knowledge of mothers of toddlers.

**CONCLUSION:**

Assessment of the knowledge of mothers regarding growth and developmental pattern of their toddlers will help us to instruct the mothers based on their learning needs which will guide them to identify the normal patterns of growth and development and deviations in normal growth and development of a child in its early stage.

**NURSING IMPLICATIONS:**

**Nursing Services:**

Nurses should be instrumental in helping the mothers of toddlers by teaching about the growth and development of their children. They study showed that nearly 50% of the mothers of toddlers do not have adequate knowledge. Nurses have to plan programmes to teach the women on the topic based on the area of their lack.

**Nursing Education:** In nursing schools and colleges, training should be given and educational programmes should be implemented for students to enable deeper understanding of the topic.

**Nursing Administration:**

There should be increase in the proportion of health care organizations, which can concentrate on growth and developmental aspect, educating mothers of how to care for their toddlers.

Nursing administrators should take interest in providing information regarding the need for organizing education programmes for the mothers on growth and development.

Nursing administrators should plan and organize such programmes with efficient team work and utilization of resources.

**Nursing Research:**

Nursing research on newer methods of imparting knowledge on the mothers of toddlers about growth and development.

**BIBLIOGRAPHY:**

Comparative study to assess the knowledge of mothers on Low Birth Weight Babies between primi and multi gravida attending OPD in Government Maternity Hospital, Tirupati.

Ms. K. Padma  
MSc (N), Asst. Prof.,  
Dept. of Medical Surgical Nursing,  
Naryana College of Nursing, Nellore.

INTRODUCTION:

Low birth weight is defined as a birth weight of a liveborn infant of less than 2,500 g (5 pounds 8 ounces) regardless of gestational age. Low birth weight (LBW) has been defined by the WORLD HEALTH ORGANIZATION (WHO) as weight at birth of less than 2,500 grams. LBW is either caused by preterm birth that is a low gestational age at birth, commonly defined as younger than 37 weeks of gestation or the infant being small for gestational age or a combination of both.

In general, risk factors in the mother that may contribute to low birth weight include young ages, multiple pregnancies, previous LBW infants, poor nutrition, heart diseases or hypertension, drug addiction, alcohol abuse and insufficient prenatal care. Environmental risk factors include smoking, lead exposure and other types of air pollutions.

A study by the Agency for Healthcare Research and Quality (AHRQ) found that of the 3.8 million births that occurred in the United States in 2011, approximately 6.1% (2,31,900) were diagnosed with low birth weight (>2,500 g). Approximately 49,000 newborns (1.3%) weighed less than 1,500 grams (VLBW).

The incidence of low birth weight, defined as the proportion of newborns weighing less than 2,500 g, is monitored through both health system surveillance and household surveys. In 2013, nearly 22 million newborns - an estimated 16 percent of all babies born globally that year - had low birth weight.

According to UNICEF, among regions South Asia has the highest incidence of low birth weight, with one in four newborns weighing less than 2,500 grams.

OBJECTIVES OF THE STUDY:

- To assess the knowledge of primigravida mothers on low birth weight babies.
- To assess the knowledge of multigravida mothers on low birth weight babies.
- To compare the knowledge of primigravida and multigravida mothers on low birth weight babies.
- To associate the demographic variables with level of knowledge on low birth weight babies among primi gravida.
- To associate the demographic variables with level of knowledge on low birth weight babies among primi gravida.

NULL HYPOTHESIS:

H₀: There is no significant difference of knowledge of mothers on low birth weight babies between primi and multi gravida.

H₁: There is no significant association of level of knowledge with their selected socio demographic variables between primi and multi gravida mothers.

MATERIALS AND METHODS:

Sampling and data collection: comparative research design, used to assess the knowledge of mothers on low birth weight babies between primi and multi gravida.. Non-probability convenient sampling of 50 mothers (25 primi and 25 multi gravida) from the OPD, Maternity Hospital were selected. mothers were between the age group of >18 years to <35 years, who were eligible, can understand regional language, who were available during data collection and voluntarily willing to participate in the study. Mothers who were not able to understand and not willing to participate were excluded.

Permission was obtained from ethical clearance committee of Maternity Hospital. Patients were informed about the study verbally; once they agreed to have their caregiver participation, then written consent from caregivers were obtained. Participants signed an informed consent and were told they could
withdraw from the study at any time for any reason.

**Data analysis:** Data was analyzed by using descriptive and inferential statistics. Frequency, percentage, mean, standard deviation and chi-square test were done.

**Results:** Assessment of knowledge on low birth weight babies among 25 primi mothers, 16 (64%) had moderately knowledge, 7 (28%) had inadequate and 2 (8%) had adequate knowledge. Among multi gravidas mothers, 13 (52%) had moderately knowledge, 6 (24%) had inadequate and 6 (24%) had adequate knowledge.

Table no:1 shows the level of knowledge among primi and multi gravida mothers on low birth weight babies:

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Mothers</th>
<th>Inadequate Knowledge</th>
<th>Moderately Adequate Knowledge</th>
<th>Adequate Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Primi</td>
<td>F=7 28%</td>
<td>F=16 64%</td>
<td>F=2 8%</td>
</tr>
<tr>
<td>2.</td>
<td>Multi gravida</td>
<td>F=6 24%</td>
<td>F=13 52%</td>
<td>F=6 24%</td>
</tr>
</tbody>
</table>

Fig no:1 shows the level of knowledge among primi and multi gravida mothers on low birth weight babies:

Table no:2 shows the overall mean and standard deviation for level of knowledge on low birth weight babies among primi and multi gravidas was as follows:

<table>
<thead>
<tr>
<th>S.no</th>
<th>Mothers</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Primi</td>
<td>12.1</td>
<td>3.24</td>
</tr>
<tr>
<td>2.</td>
<td>Multi gravida</td>
<td>13.4</td>
<td>2.89</td>
</tr>
</tbody>
</table>

In the association of demographic variables with level of knowledge on low birth weight babies between primi and multigravida mothers there is no significant association with age, education, obstetrical history, presence of medical illness during pregnancy, previous history of LBW and place of previous delivery.

**DISCUSSION:**

The discussion of the present study was based on the findings obtained from the descriptive and inferential statistical analysis of collected data. It is presented in the view of the objectives of the study.

The present study reveals that among 25 primi mothers, 16 (64%) had moderately knowledge, 7 (28%) had inadequate and 2 (8%) had adequate knowledge. Among multi gravidas mothers, 13 (52%) had moderately knowledge, 6 (24%) had inadequate and 6 (24%) had adequate knowledge. In the association of demographic variables with level of knowledge on low birth weight babies between primi and multigravida mothers there is no significant association with age, education, obstetrical history, presence of medical illness during pregnancy, previous history of LBW and place of previous delivery.

**CONCLUSION:**

The study concluded that in primi mothers majority 16 (64%) had moderately knowledge and in multi gravidas mothers 13 (52%) had moderately knowledge.

**REFERENCES:**

ARTICLE ON BETI BACHAO-BETI PADHÃO

Ms. K. Sarada,  
MSc. (N), Lecturer,  
(Community Health Nursing),  
Narayana College of Nursing,  
Nellore.

INTRODUCTION: CSR (Child Sex Ratio) is a major indicator of women disempowerment. CSR decline is about 945 in 1991 to 927 in 2001 and further 918 in 2011 is causing alarm. CSR reflects on pre-birth discrimination manifested through gender biased sex selection, and post birth discrimination against girls. It have been critical in increasing Sex Selective Elimination of girls leading to low Child Sex Ratio.

Since coordinated and convergent efforts are needed to ensure the survival, protection and empowerment of the girl child. Government has announced “Beti Bachao Beti Padhao” (BBBP) scheme in October 2014 to address the issue declining Child Sex Ratio (CSR). and our prime minister Narendra Modi launched the programme on jan 22th 2015 will be launched in 100 districs in India and 12 at Haryana.

This is being implemented through a national campaign and focussed multi sectoral action in 100 selected districts which had low in CSR and covering to all States and UTs. This is a joint initiative of Ministry of Women and Child Development, Ministry of Health and Family Welfare and Ministry of Human Resource Development.

GOAL:- Celebrate the girl child& Enable her education

OBJECTIVES:-

✓ Prevent gender biased sex selective elimination
✓ Ensure survival & protection of the girl child
✓ Ensure education of the girl child

Monitorable Targets:

✓ Reduce gender differentials in Under Five Child Mortality Rate from 8 points in 2011 to 4 points by 2017.
✓ Improve the nutrition status of girls by reducing number of underweight and anemic girls under 5 years of age.
✓ Ensure universalization of ICDS, girls attendance and equal care monitored, using joint ICDS NRHM Mother Child Protection Cards.
✓ Increase the girl’s enrolment in secondary education from 76% in 2013-14 to 79% by 2017.
✓ Provide girl’s toilet in every school in 100 CSR districts by 2017.
✓ Promote a protective environment for Girl Children through implementation of Protection of Children from Sexual Offences (POCSO) Act 2012.
✓ Train Elected Representatives/Grass root functionaries as Community Champions to mobilize communities to improve CSR and promote Girl’s education.

At the National level
Headeed by Secretary, WCD with representation from...
concerned ministries namely Ministry of Health and Family Welfare, Ministry of Human Resource Development, National Legal Services Authority, Department of Disability Affairs and Ministry of Information and Broadcasting; Gender Experts and Civil Society representatives.

At the State level

The States shall form a State Task Force (STF) with representation of concerned Departments (Health and Family Welfare; Education; Panchayati Raj/ Rural Development) including State Level Services Authority and Department of Disability Affairs to coordinate and implementation of the Scheme.

At the District level

A District Task Force (DTF) led by the District Collector/Deputy Commissioner with representation of concerned departments (Health and Family Welfare; Appropriate Authority (PC&PNDT); Education; Panchayati Raj/ Rural Development, Police) including District legal Services Authority (DLSA) will be responsible for effective implementation, monitoring & supervision of the District Action Plan.

At the Block level:

A Block level Committee would be set up under the Chairpersonship of the Sub Divisional Magistrate/Sub Divisional Officer/Block Development Officer.

At the Gram Panchayat/Ward level:

The respective Panchayat Samiti/Ward Samiti having jurisdiction over the concerned Gram Panchayat/Ward would be responsible for the overall coordination and supervision for effectively carrying out activities under the Plan.

At Village level:

Village Health Sanitation and Nutrition Committees. Frontline workers (AWWs, ASHAs and ANMs).

Budget

A budgetary allocation of 100 Cr. has been made under the budget announcement for Beti Bachao, Beti Padhao campaign and 100 Cr. will be mobilized from Plan Outlay of the Planned scheme ‘Care and Protection of Girl Child - A Multi Sectoral Action Plan’ for the 12th Plan. Additional resources can be mobilized through Corporate Social Responsibility at National & State levels. The estimated cost of the Scheme is 200 cr. Out of 200 cr., 115 cr. is proposed to be released during the current year i.e. 2014-15 (for six month). 45 Cr. Will be released during 2015-16 and 2016-17 respectively.

In an effort to motivate to open an account in the name of a girl child and for her welfare to deposit maximum of their savings up to the prescribed limits, higher rates of interest at 9.1% is proposed to be given on the deposits on annually compounded basis with income tax concession. The account will remain operative for 21 years from the date of opening of the account or marriage of the girl child after attaining 18 years of age.

Conclusion: By this scheme helps to protect and care the girl child and while sex determination of a girl can be prohibited, education for a girl child can be improved, so that reduce the girl mortality rates and helps to improve the status of a girl in the society. There should be need of awareness to public and health personnel need to motivate the public to utilize the scheme.

Net reference:

1. www.google.com- Beti Bachao, Beti Padhao p2
4. Pm Narendra Modi Invites Ideas On “Beti Bachao, Beti Padhao”
5. Pm To Launch ‘Beti Bachao, Beti Padhao’ Programme From Haryana
6. Pm Narendra Modi To Launch ‘Beti Bachao, Beti Padhao’ Programme From Haryana
In India, mother to child transmission is by far the most significant route of transmission of HIV infection in children below 15 years. Without interventions, the risk of transmission from infected mother to her child ranges from 15-25% in developed countries and 25-45% in developing countries.

- It is estimated that nearly 5% of HIV infections are attributable to parent to child transmission.
- Approximately 30% of HIV infected pregnant women will transmit HIV to their babies.
- Approximately 2.1 million children under 15 were living with HIV (2007).

The epidemic is more pronounced in urban areas than rural ones, decreases with increasing education levels and is found to be the highest among women whose spouses, work in the transport industry.

**PPTCT OR PREVENTION OF PARENT TO CHILD TRANSMISSION:** Mothers may transmit HIV to infants during pregnancy, labour, delivery or through breast feeding.

For the well being of the mother and child, it is beneficial for both parents to participate in PPTCT programme.

**RISK OF PARENT TO CHILD HIV TRANSMISSION:**

- The highest risk is during birth, then during breast feeding and then during pregnancy.

**FACTORS THAT INCREASE RISK FOR TRANSMISSION OF HIV**

<table>
<thead>
<tr>
<th>During pregnancy</th>
<th>During labour and delivery</th>
<th>During infant feeding</th>
</tr>
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<tbody>
<tr>
<td>Maternal factors</td>
<td>Newborn factors</td>
<td>factors</td>
</tr>
<tr>
<td>High viral load</td>
<td>High viral load</td>
<td>Pre term birth</td>
</tr>
<tr>
<td>Recent infection</td>
<td>-Rupture of membrane&gt;4</td>
<td>Low birth</td>
</tr>
<tr>
<td>of HIV,</td>
<td>-Intra partum haemorrhage</td>
<td>-First infant of</td>
</tr>
<tr>
<td>-Infected with HIV during pregnancy</td>
<td>-invasive disease procedures</td>
<td>multiple birth</td>
</tr>
<tr>
<td>-Advanced HIV</td>
<td>-Artificial placental</td>
<td>-Altered skin integrity</td>
</tr>
<tr>
<td>disease</td>
<td>infection rupture of</td>
<td>-Advanced infection</td>
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<tr>
<td>-Viral bacterial</td>
<td>membrane</td>
<td>-Breast pathologies</td>
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<tr>
<td>and parasitic</td>
<td>-invasive foetal monitoring</td>
<td>-Engorgement</td>
</tr>
<tr>
<td>placental</td>
<td>-Artificial infection</td>
<td>-Cracked</td>
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<tr>
<td>-Concurrent STI</td>
<td>-Invasive placental</td>
<td>-Nipples</td>
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<tr>
<td>-Malnourishment</td>
<td>-Episitomy -IDU-substance</td>
<td>-Mastitis abscess</td>
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<td>use leading to</td>
<td>-Vacuum cups -Forceps</td>
<td>-Poor maternal</td>
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<tr>
<td>risky behaviours</td>
<td>deliveries</td>
<td>nutrition</td>
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<tr>
<td>-Alterations in</td>
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<td>-Mixed feeding</td>
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<td>the integrity of</td>
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<td>(breast milk</td>
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<td>placenta, chorion</td>
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<td>along with other</td>
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<td>Chorioamnionitis</td>
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<td>foods)</td>
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<tr>
<td>Invasive procedures on the uterus</td>
<td></td>
<td>-Feeding beyond 4 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Mouth sores in infant</td>
</tr>
</tbody>
</table>

**WAYS TO PREVENT PARENT TO CHILD TRANSMISSION OF HIV:**

**Primary Prevention Before Pregnancy:**

- Education on STIs and pregnancy prevention (usage of condoms and oral contraceptives to prevent pregnancy especially for women who already have STIs or who have partners with STIs)

**A. Counselling** pregnant or lactating HIV negative women on HIV and early testing-HIV prevention during pregnancy and lactation due to high viral load during pregnancy infection and increased chances of parent to child transmission.
**B. Referrals** to STI clinic, ICTC, or PPTCT during pregnancy or lactation.

**Secondary Prevention During and After Pregnancy in HIV Positive Women:**

Nurses and patients can take many steps during pregnancy, labour, delivery and postnatal period to prevent an HIV positive mother from passing on the virus to her child.

**STEPS TO BE TAKEN DURING PREGNANCY:**
- Educate the woman on the importance of:
  - Testing for HIV
  - Antenatal visits
  - Diet + Vitamin and Iron supplements
  - Avoiding invasive procedures
  - Practicing safe sex
  - Treating any infection/STI/RTI
  - Importance of hospital delivery: indications for vaginal versus caesarean section
  - Continuing to monitor the progress of her HIV infection: CD4 counts/presence of OIs

**STEPS TO BE TAKEN DURING LABOUR AND DELIVERY:**
- Nurses should assess whether mothers have already
  - Had regular antenatal checkups
  - Had HIV testing done
  - If not, offer pre-test counselling for emergency testing (single rapid test) during labour
  - If +ve, administer single dose of NVP (nevirapine) to mother and baby
  - Counselling by ICTC counsellor and send fresh samples for conformation test
  - If mother does not receive NVP, it should be still administered to the baby:
    - If the mother is known HIV +VE, administer single dose of NVP (nevirapine) during labour and within 72 hours of birth, to the child.

**Other critical issues in labour include:**
- Disclosure & shared confidentiality
- To women, if HIV +ve status just diagnosed
- To delivery team
- To spouse and other family members
- Emotional support
- Administer Nevirapine to mother (PPTCT) Programme
- Mode of delivery
- Vaginal delivery in the hospital
- Caesarean section indicated electively only after 38 weeks of gestation, when viral load is high or as an emergency for obstetrical causes/fetal distress

<table>
<thead>
<tr>
<th>DO’s</th>
<th>DON’T’s</th>
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<tbody>
<tr>
<td><strong>For Nurse:-</strong></td>
<td><strong>For Mother During Labour:-</strong></td>
</tr>
<tr>
<td>Use appropriate personal protective equipment (PPE).</td>
<td>Isolate</td>
</tr>
<tr>
<td>Minimise splash of blood and fluids by using clamps and gauge when cutting the cord.</td>
<td>Shave pubic area</td>
</tr>
<tr>
<td>If assisting to express breast feeds, stand on the same side as mother</td>
<td>Give an enema</td>
</tr>
<tr>
<td>Importance of hospital delivery: indications for vaginal versus caesarean section</td>
<td>Perform frequent PV exams</td>
</tr>
<tr>
<td>Continuing to monitor the progress of her HIV infection: CD4 counts/presence of OIs</td>
<td>Rupture membranes</td>
</tr>
<tr>
<td>Soak all used linen in bleach solution for 2 hrs.</td>
<td>Use instrumental deliveries unless absolutely necessary</td>
</tr>
</tbody>
</table>

**For Mother During Labour:-**
- Give NVP 200mg at the onset of labour (observe outward reaction- eg:- skin rash)
- Perform vaginal cleansing with 0.25% chlorhexidine/ provide iodine
- Take measures to prevent Episiotomy

**For Newborn Care:-**
- Cut cord under cover of light gauze with a fresh blade
- Clean baby thoroughly of secretions
- Determine mothers feeding choice before latching to breast
- Give single dose NVP 2mg/kg for the baby within 72hrs of birth (observe untoward reaction- Eg:- skin rash)

- Use moth-operated suction
- Suction newborn with Nasogastric tube unless Meconium-Stained.
If these precautions are taken, there is no need to fearful of conducting or assisting in a normal delivery for HIV positive women.

**OPTIONS FOR FEEDING INFANTS OF HIV+ MOTHERS AFTER DELIVERY**

**Option 1: Breast Feeding:**
- Good hygiene
- Good position
- Give colostrum
- Exclusive breast feeding for atleast 6 months and continue breast feeding till 12 months where possible
- Never to mix feeds (never give breast milk along with other feeds such as cows milk or formula)
- Option of expressing breastfeed compared to direct feed.

**Option 2: Replacement Feeding:**
There are three safe infant feeding options. Points to keep in mind when counselling mothers on feeding options.
1. No breast feeding at all-providing cows/tinned milk
2. Breast feed exclusively for 6 months-stopping abruptly-switching to weaning foods
3. Continue breast feeding in at 6 months replacement feed is not acceptable, affordable, feasible, safe and sustainable with complementary foods

**FOLLOW UP CARE:**

**Follow up care of the mother should include:**
- Routine postnatal care
- Evaluation to decide eligibility for ART and continuing ART
- Need to report any signs of infections
- Chest, urinary, puerperal, episiotomy or breast infections, and OIs
- Reinforcement of safer sex
- Discussion of family planning BEFORE discharge
- Review birth control and infection control
- Dual protection to prevent and reduce further HIV infection, STIs, and pregnancy

**Data suggests hormonal contraception is less effective with ARV’S**

**Access to emergency contraception**

**Follow up care of baby born to HIV positive women:**
- DNA PCR HIV testing for infants (where available)
  - 6 months
  - 6 months
  - 12 months
  - 18 months
- Routine well baby visits
- Follow standard immunization schedule
- Need for immediate medical attention if signs and symptoms of any Opportunistic infection (OI) present.
- Cotrimoxazole (CPT/CTX) prophylaxis dose per kg body weight
- All HIV exposed infants start at 4-6 weeks of age till detected as HIV negative.
- HIV antibody testing at 12 months & 18 months visits.

**ROLE OF THE NURSE IN PPTCT:**
It is important for the nurses to
- Disseminate correct, non-judgemental information on PPTCT to
  - Patients
  - Families
  - Communities
  - Colleagues
- Educate on risk factors and ways to reduce risk of PPTCT during antenatal, intranatal and postnatal periods.
- Administer ARVs to lower mother’s viral load and act as prophylaxis for the baby.
- Modify obstetric practices to minimize baby’s exposure to HIV
- Support safe infant feeding practices
- Develop links for follow up of mother and baby.
01. A characteristic of infants and young children who have experienced maternal deprivation is:  
Ans: **b. Proneness to illness**  
02. The primary task to be accomplished between 12 and 15 months of age is to learn to:  
Ans: **a. Walk erect**  
03. When evaluating a 3 - year - old's developmental progress, the nurse should recognize that development is delayed when the child is unable to:  
Ans: **d. Use a spoon effectively**  
04. The average 5 - year - old is incapable of:  
Ans: **b. Abstract thought**  
05. The nurse should encourage two 6-year - old boys in the playroom to play with:  
Ans: **d. An erector set**  
06. A 7 - year - old is admitted for surgery. Preoperatively it is essential that the nurse:  
Ans: **c. Check for loose teeth and report the findings to the physician**  
07. The earliest clinical sign in idiopathic respiratory distress syndrome in a young infant is usually:  
Ans: **d. Sternal and subcostal retractions**  
08. Selection of drugs of choice for the treatment of pneumonia depends primarily on:  
Ans: **c. Sensitivity of the organism**  
09. The mostimportant nursing intervention for a 3 - year - old child with a diagnosis of nephrosis is:  
Ans: **c. Preventing inflection**  
10. If a child develops cyanosis early during a tonicclonic seizure, it is most appropriate for the nurse to:  
Ans: **d. Observe without intervening**  
11. When performing a physical assessment of a newborn with Down syndrome, the nurse should carefully evaluate the infant's:  
Ans: **a. Heart sounds**  
12. When caring for an infant with a meningomyelocele prior to surgical correction, a primary nursing goal would be to:  
Ans: **a. Prevent infection**  
13. The most serious complication of meningitis in young children is:  
Ans: **c. Peripheral circulatory collapse**  
14. An evening snack is planned for a child receiving NPH (Humulin N) insulin. The nurse understands that this will provide:  
Ans: **d. Nourishment with a latent effect to counteract late insulin activity**  
15. Under certain circumstamces the virus that causes chickenpopx can also cause:  
Ans: **b. Herpes zoster**  
16. The major influence on eating habits of the early school - aged child is the:  
Ans: **c. Example of parents at mealtime**  
17. In a baby born with a unilateral cleft lip and palate, feeding will probably be:  
Ans: **d. With a rubber - tipped syringe or medicine dropper**  
18. In cystic fibrosis, frequent stools and tenacious mucus often produce:  
Ans: **d. Rectal prolapse**  
19. Dietary treatment of children with PKU includes a:  
Ans: **b. Low - phenylalanine diet**  
20. When vomiting is uncontrolled in an infant, the nurse should observe for signs of:  
Ans: **c. Alkalosis**
Questions for qualifying examinations

Community Health Nursing

01. According to Holistic concept, health is considered as: ( )
   a. Absence of disease
   b. Proper adequate environment
   c. Good interpersonal relationship
   d. Sound body with sound mind living in sound family surrounded by sound environment

02. Which of the following is not the pre-requisite of health promotion: ( )
   a. Educate
   b. Unhealthy practices
   c. Enable
   d. Mediate

03. What are the constituents of chromosomes? ( )
   a. Chromatin
   b. Centeromere
   c. Genes
   d. All of above

04. Dominant gene has its effect in: ( )
   a. homozygous state
   b. heterozygous
   c. a & b
   d. None of above

05. All are Primary pollutant from the following: ( )
   a. Fumes
   b. Mist
   c. Ozone
   d. Sprays

06. What is the wavelength of electromagnetic: ( )
   a. 100 to 150 nm
   b. 150 to 370 nm
   c. 380 to 760 nm
   d. 760 nm to 1000 nm

07. When was the first slow sand filter devised?: ( )
   a. In 1990
   b. In 1820
   c. In 1829
   d. In 2000

08. Chlorin tablets required to disinfect the water: ( )
   a. 1 tablet (0.5 gm) to disinfect 5 Lts of water
   b. 1 tablet (0.5 gm) to disinfect 10 Lts of water
   c. 1 tablet (0.5 gm) to disinfect 15 Lts of water
   d. 1 tablet (0.5 gm) to disinfect 20 Lts of water

09. Which of the following is volume reduction method: ( )
   a. Trench method
   b. Incineration method
   c. Ramp method
   d. Area method

10. In which year Royal Commission recommended sanitary commission: ( )
    a. 1759
    b. 1859
    c. 1900
    d. 1948

11. Sixth five year plan: ( )
    a. 1985 - 1990
    b. 1981 - 1985
    c. 1969 - 1974
    d. 1951 - 1955

12. Revised National Tuberculosis control programme was launched in 1993 with: ( )
    a. DOTS therapy
    b. CCH
    c. National leprosy eradication programme
    d. RNTCP

13. Kartar committee: ( )
    a. 1973
    b. 1962
    c. 1963
    d. 1975

14. When was the central council of health was composed? ( )
    a. 1940
    b. 1948
    c. 1952
    d. 1968

15. Under Community Development Project, each block comprises: ( )
    a. 40,000 population
    b. 80,000 population
    c. 70,000 population
    d. 1,00,000 population

16. Each municipal co-operation covers a population of: ( )
    a. Two lakhs & above
    b. Four lakhs & above
    c. Six lakhs & above
    d. None of above

17. National Nutritional Anaemia Prophylaxis Programme: ( )
    a. 1970
    b. 1946
    c. 1986
    d. 1975

18. National Mental Health Programme: ( )
    a. 1983
    b. 1982
    c. 1997
    d. 1974

19. Care: ( )
    a. 1946
    b. 1927
    c. 2002
    d. April 7, 1948

20. CSSW: ( )
    a. 1949
    b. 1919
    c. 1939
    d. 1953
P Values

The P value or calculated probability is the estimated probability of rejecting the null hypothesis \( (H_0) \) of a study question when that null hypothesis is true. In other words, the P-value may be considered the probability of finding the observed, or more extreme, results when the null hypothesis is true - the definition of ‘extreme’ depends on how the hypothesis is being tested.

The null hypothesis is usually an hypothesis of “no difference” e.g. no difference between blood pressures in group A and group B. The one sided P value is used when a large change in an unexpected direction would have absolutely no relevance to the study. This situation is unusual; if there is in any doubt then uses a two sided P value.

The term significance level (alpha) is used to refer to a pre-chosen probability and the term “P value” is used to indicate a probability that calculated after a given study.

The alternative hypothesis \( (H_1) \) is the opposite of the null hypothesis.: For example, question is “is there a significant (not due to chance) difference in blood pressures between groups A and B, if we give group A the test drug and group B a sugar pill?” and alternative hypothesis is “there is a difference in blood pressures between groups A and B after intervention.”

If P value is less than the chosen significance level then reject the null hypothesis i.e. accept that sample gives reasonable evidence to support the alternative hypothesis.

The choice of significance level at which reject \( H_0 \) is arbitrary. Conventionally the 5% (less than 1 in 20 chance of being wrong), 1% and 0.1% \( (P < 0.05, 0.01 \) and 0.001) levels have been used. These numbers can give a false sense of security.

In the ideal world, we would be able to define a “perfectly” random sample, the most appropriate test and one definitive conclusion. What we can do is try to optimise all stages of our research to minimise sources of uncertainty. When presenting P values some groups find it helpful to use the asterisk rating system as well as quoting the P value:

- \( P < 0.05 \) *
- \( P < 0.01 \) **
- \( P < 0.001 \)

Most authors refer to statistically significant as \( P < 0.05 \) and statistically highly significant as \( P < 0.001 \) (less than one in a thousand chance of being wrong).

The asterisk system avoids the woolly term “significant”. Please note, however, that many statisticians do not like the asterisk rating system when it is used without showing P values. As a rule of thumb, if you can quote an exact P value then do. You might also want to refer to a quoted exact P value as an asterisk in text narrative or tables of contrasts elsewhere in a report.

At this point, a word about error. Type I error is the false rejection of the null hypothesis and type II error is the false acceptance of the null hypothesis. As an aid memoir: think that our cynical society rejects before it accepts.

The significance level (alpha) is the probability of type I error. The power of a test is one minus the probability of type II error (beta). Power should be maximised when selecting statistical methods. If you want to estimate sample sizes then you must understand all of the terms mentioned here.

The following table shows the relationship between power and error in hypothesis testing:

<table>
<thead>
<tr>
<th>DECISION</th>
<th>TRUTH</th>
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<tbody>
<tr>
<td>Accept ( H_0 ):</td>
<td>( H_0 ) is true: correct decision ( P ) ( 1 - \alpha ) ( \alpha ) (sig)</td>
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<tr>
<td></td>
<td>( H_0 ) is false: Type II error ( P ) ( \beta ) ( 1 - \beta ) (power)</td>
</tr>
</tbody>
</table>

**Confidence intervals** if intend to quote P values in reports and papers. Statistical referees of scientific journals expect authors to quote confidence intervals with greater prominence than P values.
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3. The heading of the article must be typed along with authors name and title which are meant for publication.
4. The articles, abstracts etc. may be submitted through e-mail: narayananursingjournal@gmail.com incase the article is sent by post the hard copy must accompany on CD.
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<td>200 x 4 = 800</td>
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